

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02891

131a

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 21 Years

Hospital, institution, or street address where death occurred:

4796 Western Ave.How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4796 Western Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

Labibi Daoud Ackad

## 3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Widowed</u>

6.(b) Name of husband or wife Ferris K. Ackad6.(c) If alive, give age Dec. years7. Birth date of deceased (mo., day, yr.) May 22, 1874

8. AGE:	Years	Months	Days	It less than one day
<u>73</u>	<u>73</u>	<u>9</u>	<u>10</u>	<u>hrs.</u> <u>min.</u>

9. Birthplace Lebanon, Syria  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business None12. Name George Daoud13. Birthplace Lebanon, Syria14. Maiden name Rinjus Sackat15. Birthplace Lebanon, Syria16. Informant Abdon D. AckadAddress 4796 Western Ave, Chevy Chase17. Burial Prospect Hill Cemetery(Burial, cremation, or removal. Which?) Date thereof Mar 4, 1948  
(month) (day) (year)Cemetery or crematory Washington, D. C.Location Washington, D. C.19. Funeral director Wm. E. JonesAddress Bethesda, Maryland19. Mar 4 1948 Wm E Jones

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1948 at 5:40 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8, 1948 to March 2, 1948and that I last saw him alive on Feb 27, 1948Immediate cause of death Coronary artery diseaseHeart failureDue to Coronary-vascular-renal diseaseDue to 5 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

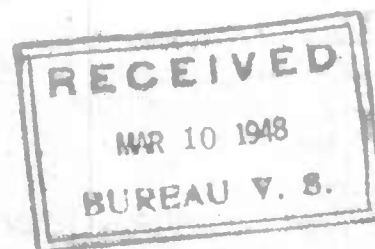
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm E Jones M. D. or otherAddress 3921 Longview Ave Date signed 3/3/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 hours  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital - Old Georgetown Rd  
 How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bethesda - Cherry Chase Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 107 East Bradley Lane  
 (If rural, give LOCATION)  
 2(a) If veteran, name war None

## 3. (a) FULL NAME

AKA Mrs. Core B.  
 4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow  
 8. (b) Name of husband or wife James Nelson AKA  
3 April - 1978 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 30, 1988  
 8. AGE: Years 66 Months 9 Days 19 If less than one day 16 hrs. 5 min.

9. Birthplace Phillipsburg, Clearfield Co., Penna.  
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Housewife

12. Name Thomas S. Bellis

13. Birthplace Oldham, England

14. Maiden name Ellen Lamb

15. Birthplace Oldham, England

16. Informant Mrs. W. C. Kinscannon

Address 107 East Bradley Lane, Cherry Chase, Md.

17. Burial-Transit Burial-Transit Date thereof March 23, 1988  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Egg Harbor Cemetery

Location Egg Harbor, New Jersey

18. Funeral director Wm. Andrew Humphrey

Address Bethesda, Maryland

19. MAR 22 1988 Mr. E. Jones  
 (Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH 19 March 1988 at 4:05 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 August 1986, to 19 March 1988

and that I last saw her alive on 19 March 1988.

Immediate cause of death Cerebral Colloidal with Cardiac Failure  
Thrombotic abdominal aorta

Due to Cardiac Decomposition 17 Dec 47

vascular fibrillation 18 Dec 47

Due to atrial Hypertension 25 yrs.

Cardiac Hypertrophy - increasing 10 yrs?

Other conditions Nephritis - date generalized 20 yrs?

arterio sclerosis 20 yrs?

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

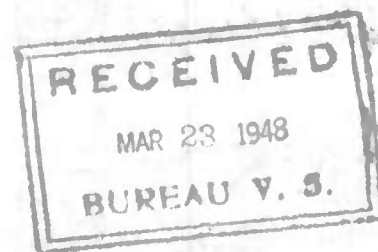
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John S. Ball M.D.

Address 7955 Georgetown Rd Bethesda, Md. M. D. or other \_\_\_\_\_ Date signed 19 March 88

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02893

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 22 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 month, 22 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Wis. County \_\_\_\_\_  
 City or town Eleva  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

BABCOCK, Ralph LaVerne, Cpl. USMC

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife \_\_\_\_\_ 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 12 August 1929  
 8. AGE: Years 18 Months 2 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Wis.  
 (Town, county, and state)  
 10. Usual occupation Marine Corps  
 11. Industry or business \_\_\_\_\_  
 12. Name BABCOCK, Gail  
 13. Birthplace Wis.  
 14. Maiden name unknown (deceased)  
 15. Birthplace Wis.

16. Informant FATHER: Mr. Gail Babcock  
 Address Eleva, Wis.  
 17. burial Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Eleva Cemetery  
 Location Eleva, Wis.  
 18. Funeral director W. W. CHAMBERS  
 Address 1400 Chapin St., N.W., Wash., D.C.  
 19. 3-4 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3 March 48 6:30 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
10 January 48 to 3 March 48  
 and that I last saw h. in alive on 3 March 48  
 Immediate cause of death Lympho-sarcoma, recticulum cell type DURATION 7 mos.  
 Other conditions Sarcomatosis of most of right lung, atelectasis of remaining portion of right lung, massive right pleural effusion, oedema of left lung  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results Confirmed Above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 Means of injury W. F. HARRISON, Jr., Lt. MC USN  
 23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 3-4-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02894

216

Reg. Dist. No.

1. PLACE OF DEATH:  
County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Va. County \_\_\_\_\_  
City or town Arlington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2526 N. Washington Blvd.  
(If rural, give LOCATION)  
2.(a) If veteran, name war Sp. Am. War

### 3. (a) FULL NAME

BAUM, William Thomas

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Katherine Mary Baum  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) January 7, 1880  
8. AGE: Years 68 Months 2 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
(Town, county, and state)  
10. Usual occupation unknown  
11. Industry or business \_\_\_\_\_  
FATHER 12. Name BAUM, John dec. \_\_\_\_\_  
13. Birthplace Md.

MOTHER 14. Maiden name unknown dec. \_\_\_\_\_  
15. Birthplace unknown

16. Informant wife: Mrs. Katherine M. Baum  
Address 2526 N. Washington Blvd., Arlington, Va.

17. burial Date thereof 3-12-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Arlington, Va.  
Location

18. Funeral director S. H. HINES  
Address 2901 14th St., N. W., Wash., D.C.  
Mary C. Patterson

19. 3-9- 19 48  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 19 48 at 6:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 March 19 48 to 9 March 19 48  
and that I last saw him alive on 9 March 19 48

Immediate cause of death Broncho pneumonia DURATION one wk?

Due to thrombosis Coronary Artery one wk.  
with infarction (7 days)

Due to Coronary artery disease indef.  
arterio sclerosis

Other conditions pulmonary edema  
allops. hydrothorax right.  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results As Above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE F. E. WETZEL LT MC USN  
M. D. or other

Address USNH Bethesda, Md. Date signed 3-9-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02895

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Cherry Chase Md  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery  
City or town Cherry Chase Ward No.  
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 6327 Meadow Lane  
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

### 3. (a) FULL NAME

DR CHARLES H. BEACH

### 3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife ANNE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-1875

8. AGE: Years 72 Months 5 Days 6 If less than one day hrs. min.

9. Birthplace WHEELING WEST, VA  
(Town, county, and state)

10. Usual occupation DENTIST

11. Industry or business

12. Name CHARLES H. BEACH

13. Birthplace WEST, VA

14. Maiden name EUGENIA O'Leary

15. Birthplace WEST VA

16. Informant MRS. ANNE BEACH

Address 6327 Meadow Lane

17. Burial Date thereof 3 7 1948  
(Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cem

Location

18. Funeral director P. J. Saffell

Address 4754 H - 30 N.W

19. 3-7 19 48 W. E. Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7-1948, at 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-1- 19 48, to 3-7- 19 48

and that I last saw him alive on 3-2- 19 48

Immediate cause of death Acute Heart Failure DURATION 1 hour

Due to Chronic Myo-  
carditis

Due to Carditis DURATION Several years

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Logan Owens, M.D. M. D. or other

Address 1316 N. Han Date signed 3-7-48  
Washington DC

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be submitted. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3-7/47.

Notified Coroner of  
this death. He entrusted  
me to sign Death Certificate.

S. Logan Oliver, M.D.  
1816 7/4 H. Ave.,

RECEIVED

MAR 10 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02896

Reg. Dist. No. 223

### 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
211 Maple Ave.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)  
State MD. County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 211 Maple Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Miss. Annie C. Bennett

### 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Single

### 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct-1-1858 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 89 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Culpepper - Va.  
(Town, county, and state)

10. Usual occupation At Home

### 11. Industry or business

12. Name John William Bennett  
13. Birthplace England  
14. Maiden name Eliza Williams  
15. Birthplace England

16. Informant Luke Bennett  
Address 211 Maple Ave. Takoma Park

17. (Burial, cremation, or removal, which?) Burial Date thereof Mar. 15-1948  
(month) (day) (year)

Cemetery or crematory Cedar Hill  
Location Prince George's Co., Md.

18. Funeral director J. Walter Walters  
Address 754 Congress St. Takoma Park

19. March 14 1948  
(Date rec'd by registrar) Registrar J. Walter Walters

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12 March 19 48, at 3<sup>10</sup> P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 April 19 46, to 12 March 19 48  
and that I last saw him alive on 11 March 19 48

Immediate cause of death Coronary Failure  
(Myocardial Heart Disease) DURATION 5-10 yrs.

Due to Arteriosclerosis Myocardial 10-15 yrs.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE J. B. Sullivan M.D. M. D. or other \_\_\_\_\_  
Address Takoma Park, Md Date signed 12 March 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 16 1948

**BUREAU V. S.**



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

02897

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery Co.City or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since 3-12-48Hospital, institution, or street address where death occurred: Suburban Hosp.  
8600 Old Georgetown Rd. - Bethesda Md.How long in hospital or institution? Since 3-12-48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4611 W. Virginia Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

William H. Benson

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Nettie - Deceased

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Sept. 10, 1860

8. AGE:

Years

Months

Days

If less than one day

87610

hrs.

min.

9. Birthplace Montgomery Co. Maryland  
(Town, county, and state)10. Usual occupation Retired (handy-man)

11. Industry or business

12. Name Allan Benson13. Birthplace Montgomery Co. Maryland14. Maiden name Mary Brashers15. Birthplace Montgomery Co. Maryland16. Informant Mr. A. C. BensonAddress Bethesda, Maryland17. Burial Date thereof Mar 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Beallsville, CemeteryLocation Beallsville, Maryland18. Funeral director Wm. Landon PumphreyAddress Bethesda, Maryland19. 3/20 19 48  
(Date rec'd by registrar)Wm E Jones  
Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 19 48 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 6, 1947 to Mar 20, 1948and that I last saw him alive on Mar 20, 1948

Immediate cause of death

Acute cardiac failure

DURATION

1 wkDue to Generalized arteriosclerosis10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

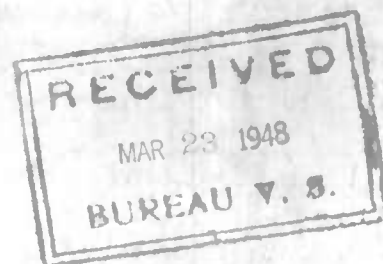
23. SIGNATURE

Emil G. Bauerfeld M.D.  
Bethesda Md Date signed 3/20/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 28 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 months, 28 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2802 Pomroy Road, S.E., Apt. #4  
 (If rural, give LOCATION)  
WWII  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

BROWN, Oliver

## 3. (b) Social Security Number

4. Sex male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Bluette Y. Brown  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) January 10, 1921  
 8. AGE: Years 27 Months 1 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D. C.  
 (Town, county and state)  
 10. Usual occupation Photostat Operator  
 11. Industry or business Government (War Dept.)  
 12. Name BROWN, Charles E.  
 13. Birthplace Wash., D.C.  
 14. Maiden name HALL, Bessie  
 15. Birthplace Va.

16. Informant wife: Mrs. Bluette Y. Brown  
 Address 2802 Pomroy Road, S.E., Apt. #4, Wash., D.C.  
 17. burial Date thereof \_\_\_\_\_ (month) (day) (year)  
 (Burial, cremation, or removal, Which?)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director W. Ernest Jarvis & L.H.  
 Address 1432 U St., N.W., Wash., D.C.  
 19. 3-3 19 48 Mary C. Patterson Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3 March 19 48 at 2:50A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 Dec. 19 47 to 3 March 19 48  
 and that I last saw him alive on 3 March 19 48  
 Immediate cause of death Bronchopneumonia  
Neurofibromatosis  
 Due to Neurofibromatosis  
with malignant  
 Due to Degeneration  
 Other conditions Malignant tumor, primary site, pelvic nerve  
 (Include pregnancy within 8 months of death) [5/4/48 at]

## DURATION

2 days8 mos.

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury E. N. Weaver Injured at work? \_\_\_\_\_  
 23. SIGNATURE E. N. WEAVER, Lt. JG MCR USNR  
 M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 3-3-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

83a

02899

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County.....*Montgomery*  
 City or town.....*E. Maryland*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Montgomery*  
 City or town.....*E. Maryland*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....*Quintana Rd.*  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*James R. Braxton*

## 3. (b) Social Security Number

4. Sex

*Male*

5. Color or race

*Caucasoid*

6.(a) Single, married, widowed, or divorced

*Widowed*

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.).....*June 23, 1893*  
 6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

*63*..... hrs. .... min.

9. Birthplace

*Montgomery Co. Maryland*  
(Town, county, and state)

10. Usual occupation

*Labrador*

11. Industry or business

*Lawrence Braxton*

FATHER

12. Name

*md.*

13. Birthplace

*Arise Luckett*

MOTHER

14. Maiden name

*Maryland*

15. Birthplace

*John Braxton (son)*

16. Informant

*Emory Maryland*

Address

*Burial*

17. (Burial, cremation, or removal. Which?)

Date thereof.....*March 28, 1948*  
(month) (day) (year)

Cemetery or crematory

*Church Cemetery*

Location

*E. Maryland*

18. Funeral director

*R. R. Snowden*

Address

*Rockville, Md.*19. *March 28, 1948* *Abdul G. Sorbe*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*March 25, 1948*.....*at 10:00 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....*1946* to.....*Mar 25, 1948*and that I last saw him alive on.....*Mar 23, 1948*

Immediate cause of death.....

*Cerebral hemorrhage*Due to.....*hypertension*Due to.....*2 yrs.*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

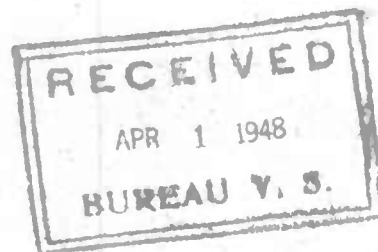
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Frank J. Braxton Md*Address.....*Yarshington Md* Date signed.....*3-28-48*



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02900

Reg. Dist. No. 214

### 1. PLACE OF DEATH:

County Montgomery  
City or town Chesler Spring Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution? X

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Chesler Spring  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 8506 Houston St  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

### 3. (a) FULL NAME

Carl E. Burre.

### 3. (b) Social Security Number

#### 4. Sex

M

#### 5. Color or race

W

#### 6. (a) Single, married, widowed, or divorced

W

### 6. (b) Name of husband or wife

May G Burre

### 6. (c) If alive, give age

60 years

### 7. Birth date of

deceased (mo., day, yr.) Oct 11 - 1888

### 8. AGE:

Years 59 Months Days It less than one day hrs. min.

### 9. Birthplace

Quincy Ill  
(Town, county, and state)

### 10. Usual occupation

### 11. Industry or business

### 12. Name

### 13. Birthplace

### 14. Maiden name

### 15. Birthplace

### 16. Informant

May G Burre  
Address 8506 Houston St

### 17. Burial

Date thereof 3 9 48  
(month) (day) (year)

### Cemetery or crematory

Rock Creek

### Location

Washington, D.C.

### 18. Funeral director

W. H. Jones Co  
Address 2901-14 St N.W.

### 19. Date rec'd by registrar

May 5 1948  
Josephine S. Schaeffer  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5 48 at 7:30 P. M.

### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 45 to March 5 48  
and that I last saw him alive on 3/4 48

### Immediate cause of death

Coronary thrombosis

### DURATION

acute

### Due to

arteriosclerosis

### Due to

### Other conditions

diabetes mellitus

5 yrs

(Include pregnancy within 8 months of death)

### Major findings of operations

### Autopsy results

none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

### 23. SIGNATURE

S. W. Nealon Jr. M.D.

Address 1746 K. St N.W. Date signed 3/5/48

Wash. D.C.

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 8 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 212

02901

526

## 1. PLACE OF DEATH:

County... MontgomeryCity or town... Poolesville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 68 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 2 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montg.City or town... Poolesville, Md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2(a) If veteran, name war.....

## 3. (a) FULL NAME

William George Butler

## 3. (b) Social Security Number

None4. Sex M5. Color or race W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June - 20 - 18798. AGE: Years 68 Months 8 Days 21 If less than one day

..... hrs. .... min.

9. Birthplace Poolesville, Montg. Co. Md  
(Town, county, and state)10. Usual occupation U.S. Mail Carrier

11. Industry or business

12. Name Charles M. Butler13. Birthplace Virginia14. Maiden name Francis Spates15. Birthplace Maryland16. Informant ROSE E. ButlerAddress Poolesville, Md17. Burial Date thereof 3/13/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetary or crematory MonocacyLocation Beallsville, Md18. Funeral director William B HiltonAddress Barnesville, Md19. March 12, 1948 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1948 at 8:45 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1947 to March 11, 1948and that I last saw him alive on March 10, 1948

Immediate cause of death.....

Cardio-respiratory failureDue to Carcinoma of the urinary bladder

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations Fungating carcinoma of bladder & metastasisAutopsy results 22 Date of op. 1947

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE R. W. Adams (md)Address Poolesville, Md M. D. or otherDate signed 3/14/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

**RECEIVED**

MAR 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

02902

## CERTIFICATE OF DEATH

Reg. Dist. No. 2.6

## 1. PLACE OF DEATH:

County Montgomery Bethesda  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 da. 1 hr. 23 mins.  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital, Old Geo. Rd.  
 How long in hospital or institution? 1 da. 1 hr. 23 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... County.....  
 City or town..... Washington D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2917 North Capitol St. N.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

InfantCampbell

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.) March 21- 1948 6.(c) If alive, give age..... years  
 8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 1 If less than one day \_\_\_\_\_ hrs. 23 min.

9. Birthplace Bethesda Montgomery, Maryland  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name James Joseph Campbell

13. Birthplace Philadelphia Penn

14. Maiden name Anna Yahya

15. Birthplace Cleveland Ohio

16. Informant Anna Yahya

Address 2917 N. Capitol St. N.E. D.C.

17. CREMATION Date thereof MARCH 23 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory SUBURBAN HOSPITAL

Location 8600 OLD GEORGETOWN RD - BETHESDA, MD

18. Funeral director A.B. Saloon / Supr

Address BETHESDA 14, Md

19. 3/24 19 48 Wm E Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 19 48 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 19 48 to March 22 19 48  
 and that I last saw him alive on March 21 19 48

Immediate cause of death Prematurity (25 weeks) DURATION 1 day

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

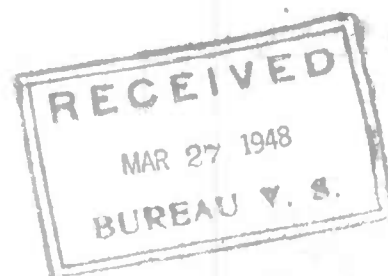
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Samuel Hienner M.D. M.D. or other

Address 2805 Ashway N.W. Date signed 3/22/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02903

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Dilmeys Rural  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

10 days

Hospital, institution, or street address where death occurred:

Montgomery County General Hospital  
 How long in hospital or institution? 10 days

## 3. (a) FULL NAME

CLARENCE A

CHAPMAN

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, or divorced

Married

6. (b) Name of husband or wife

Lillie Chapman

7. Birth date of deceased (mo., day, yr.)

July 18, 1872

6. (c) If alive, give age

72 years

8. AGE:

Years

Months

Days

If less than one day

75

7

15

hrs.

min.

9. Birthplace

Boys, Montgomery Co., Md.  
 (Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER  
 FATHER

12. Name

Henry Chapman

13. Birthplace

Bridgeport Connecticut

14. Maiden name

Rebecca Henley

15. Birthplace

Hunting Hill, Md.

16. Informant

Hospital records

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

3-5-48 (month) (day) (year)

Cemetery or crematory

St Marys Cemetery

Location

Rockville, Md.

18. Funeral director

Wm R. Humphrey

Address

Bethesda, Maryland

19.

March 3, 1948

1948

Gertrude B. Fowler

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Hensington  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1948 at 6<sup>01</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 21, 1948 to March 3, 1948  
 and that I last saw him alive on March 3, 1948

Immediate cause of death

Cardiac insufficiency

DURATION

2 yrs

Due to

Hypertensive Cardiovascular Disease

7 years

Due to

Arteriosclerotic nephrosclerosis

7 years

Other conditions

Uremia

7 weeks

Parkinsonism

2-3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

JMRB '1

M. D. or other

Address Sandy Spring, Md Date signed 3/3/48

RECEIVED

MAR 12 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02904

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Westmoreland Hills  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County montgomery  
City or town Westmoreland Hills  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5303 Mass. Ave  
(If rural, give LOCATION)  
2. (a) If veteran, name war None

### 3. (a) FULL NAME

GEORGE EDWIN CHAPPELEAR

### 3. (b) Social Security Number

#### 4. Sex

Male

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Married

#### 6. (b) Name of husband or wife

Angie Herbert Chappellear

#### 7. Birth date of deceased (mo., day, yr.)

August 13, 1867

#### 6. (c) If alive, give age

77

#### 8. AGE:

Years

Months

Days

If less than one day

80

6

20

hrs.

min.

#### 9. Birthplace

Hughesville, Maryland

(Town, county, and state)

#### 10. Usual occupation

Insurance

#### 11. Industry or business

#### FATHER

#### 12. Name

George Chappellear

#### 13. Birthplace

Hughesville, Maryland

#### MOTHER

#### 14. Maiden name

Mary Emily Montgomery

#### 15. Birthplace

Hughesville, Maryland

#### 16. Informant

Mrs Angie Herbert Chappellear

#### Address

5303 Mass Ave, Maryland

#### 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

3/9/48

#### Cemetery or crematory

Cedar Hill Cem

#### Location

B. H. Hines Co

#### 18. Funeral director

#### Address

2901-14th St. N.W.

#### 19. (Date rec'd by registrar)

3/7/48

19

48

Wm E Jones

Registrar

### MEDICAL CERTIFICATION

#### 20. DATE OF DEATH

July 7 3/7/48

19

48 at 1:30 P.M.

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1948 to July 7 1948  
and that I last saw him alive on July 6 1948

#### Immediate cause of death

Cerebral hemorrhage

#### DURATION

4 days

#### Due to

Cerebral regional arterio sclerosis

6 yrs. +

#### Due to

#### Other conditions

Chronic myocarditis

years

(Include pregnancy within 3 months of death)

#### Major findings of operations

Date of op.

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

#### 23. SIGNATURE

Address

M. D. or other

Date signed

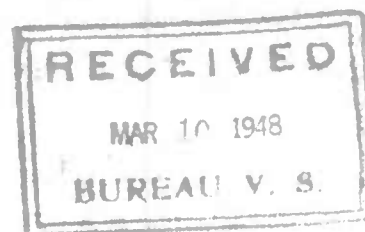
3/7/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



100-100000-100000  
MAR 10 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02905

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2108 Dayton St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2108 Dayton St.

(If rural, give LOCATION)

no

2.(a) If veteran, name war

## 3. (a) FULL NAME

Wilbur R. Clements

## 3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Madeline

7. Birth date of

deceased (mo., day, yr.)

August 22, 1885

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

62428

hrs.

min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Steven A. Clements

13. Birthplace

Washington, D.C.

MOTHER

14. Maiden name

Elizabeth McCauley

15. Birthplace

Washington, D.C.

16. Informant

Mrs Robert L. Guy

Address

2108 Dayton St. Silver Spring

17.

Burial

Date thereof

Mar. 24, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

Suitland, Maryland.

18. Funeral director

Warner E. Humphrey

Address

8434 Ga. Ave., Silver Spring, Md.

19.

Mar 21, 1948

(Date rec'd by registrar)

Joseph H. Schaeffer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1948 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 19, 43. to March 20, 1948and that I last saw him alive on March 20, 1948Immediate cause of death Coronary insufficiency

DURATION

?Due to arterio-sclerosis ?

Due to

Other conditions Mitral disease of heart. Mitral insufficiency ?

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE Walter K. Angermeier M.D.

M. D. or other

Address 6300-13th St. NW, Wash. D.C. Date signed 3/21/48

**RECEIVED**

MAR 29 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02906

## CERTIFICATE OF DEATH

Reg. Diat. No. 223

### 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 months  
Hospital, institution, or street address where death occurred:  
304 Longbranch Parkway  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 304 Longbranch Parkway  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Caroline Amanda Cobb

### 3. (b) Social Security Number

### 4. Sex

Female

### 5. Color or race

White

### 6. (a) Single, married, widowed, or divorced

Widowed

### 6. (b) Name of husband or wife

Stephen M. Cobb

### 6. (c) If alive, give age years

### 7. Birth date of deceased (mo., day, yr.)

Feb. 20, 1856

### 8. AGE:

Years

Months

Days

It less than one day

92

0

24

hrs. min.

### 9. Birthplace

No. Stockholm, N.Y.  
(Town, county, and state)

### 10. Usual occupation

housewife

### 11. Industry or business

### FATHER

### 12. Name

(First unknown) Reddington

### 13. Birthplace

### MOTHER

### 14. Maiden name

Unknown

### 15. Birthplace

### 16. Informant

Mrs. Anna Cobb

Address 304 Longbranch Parkway, Takoma Park, Md.

### 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar 19, 1948  
(month) (day) (year)

### Cemetery or crematory

Templeville

### Location

Templeville, Md.

### 18. Funeral director

Raymond B. Rawlings

### Address

Templeville, Md.

### 19. (Date rec'd by registrar)

Mar. 16, 1948

F. Nelson Dodd  
Registrar

### MEDICAL CERTIFICATION

### 20. DATE OF DEATH

March 16

1948 at 12:30 P.

### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

27 August

1947 to 16 March 1948

and that I last saw him alive on Feb. 10

### Immediate cause of death

Congestive heart failure

### Due to

Arteriosclerotic and  
hypertensive cardiovascular  
disease

### Due to

### Other conditions

(Include pregnancy within 3 months of death)

### Major findings of operations

### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

### 23. SIGNATURE

Russell A. Dunn

M.D.

Address Washington Sen. & Hospital

Date signed March 16, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 18 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County \_\_\_\_\_  
City or town Washington, D.C.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 607 L St., N.E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

COLEMAN, William (n), VAP

### 3. (b) Social Security Number

4. Sex male 5. Color or race Col 6.(a) Single, married, widowed, or divorced widowed  
6.(b) Name of husband or wife \_\_\_\_\_  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) 25 December 1855  
8. AGE: Years 92 Months 2 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
(Town, county, and state)  
10. Usual occupation unemployed  
11. Industry or business \_\_\_\_\_

FATHER 12. Name unknown  
13. Birthplace unknown  
MOTHER 14. Maiden name unknown  
15. Birthplace unknown

16. Informant daughter: Mrs. Jannie V. Dandridge  
Address 607 L St., N. E., Wash., D.C.

17. Burial Date thereof 3-15-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Virginia

18. Funeral director W. Ernest Jarvis  
Address 1432 U St., N.W. Washington D. C.

19. 3-10 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 10 March 19 48 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 March 19 48 to 10 March 19 48  
and that I last saw him alive on 10 March 19 48

Immediate cause of death Bronchopneumonia DURATION 36 hrs.

Due to Nephritis Chronic with uremia unknown

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury Automobile Injured at work? \_\_\_\_\_

A. E. MARIAND, Jr. Lt. JG MC USN

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 3-10-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 13 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02908

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County... **Montgomery**  
 City or town... **Bethesda (rural)**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **2 days**  
 Hospital, institution, or street address where death occurred:  
**US Naval Hospital, Bethesda, Md.**  
 How long in hospital or institution? **2 days**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... **D.C.** County...  
 City or town... **Washington**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... **2928 33rd Place, N. W.**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... **WWI**

## 3. (a) FULL NAME

**COOK, Frederick Morgan**

## 3. (b) Social Security Number

4. Sex... **male** 5. Color or race... **W-US** 6. (a) Single, married, widowed, or divorced... **married**  
 6. (b) Name of husband or wife... **Mrs. Maude M. Cook**  
 7. Birth date of deceased (mo., day, yr.)... **October 2, 1896** 6. (c) If alive, give age... years  
 8. AGE: Years... **51** Months... **5** Days... **6** It less than one day... hrs. min.

9. Birthplace... **Washington, D. C.**  
 (Town, county, and state)  
 10. Usual occupation... **Lawyer**  
 11. Industry or business  
 12. Name... **COOK, Jesse dec.**  
 13. Birthplace... **Pa**  
 14. Maiden name... **SWEENEY, Cedila dec.**  
 15. Birthplace... **Pa.**

16. Informant... **wife: Mrs. Maude M. Cook**  
 Address... **2928 33rd Place, N. W., Wash., D.C.**  
 17. **burial** Date thereof... (month) (day) (year)  
 (Burial, cremation, or removal. Which?)  
 Cemetery or crematory... **Arlington National**  
 Location... **Arlington, Va.**

18. Funeral director... **S. H. HINES 886**  
 Address... **2901 14th St., N.W., Wash., D.C.**

19. **3-8** 19 **48** **Mary C. Patterson**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... **8 March** 19 **48** at **6:40 A.** M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **6 March** 19 **48** to **8 March** 19 **48**

and that I last saw him alive on 19

Immediate cause of death... **airbosis, liver** DURATION **over 1 yr**

Due to... **Edema, lung** **2 hrs**  
 Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results... **airbosis, liver; edema, lung**  
 PHYSICIAN: Please underline the cause to which death should be charged statitically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

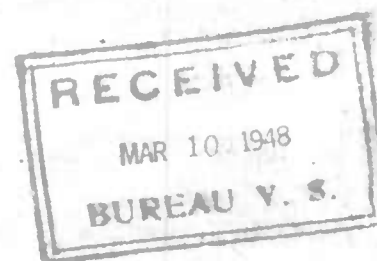
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury **R. L. FIECK** Injured at work?

23. SIGNATURE... **R. L. FIECK, Lt MC USN** M. D. or other

Address... **USNH Bethesda, Md.** Date signed... **3-8-48**





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02909  
Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County Montgomery County  
City or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Months  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. # 2  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

HENRY LOUD CRANFORD II

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Myrtle L. Cranford

7. Birth date of deceased (mo., day, yr.) July 14, 1894 6. (c) If alive, give age Dec. years

8. AGE: Years 53 Months 53 Days 8 It less than one day 9 hrs. min.

9. Birthplace Washington, D. C.  
(Town, county, and state)

10. Usual occupation Cont. Engineer

11. Industry or business

12. Name Joseph H. Cranford13. Birthplace Brooklyn, New York14. Maiden name Ada B. Tyssowski15. Birthplace Washington, D. C.16. Informant Lt. Col. L. Filbert CranfordAddress R.F.D. #2, Rockville, Md.

17. Burial Date thereof March 27, '48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.18. Funeral director Wm. Ransom HumphreyAddress Rockville, Maryland

19. 3/27 48  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 24th, 1948, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1947 to March 24, 48  
and that I last saw him alive on March 24, 48

Immediate cause of death

DURATION

Cerebral edema 1 day

Due to: Congestive Failure 5 days

Due to: hypertension 5 years

Other conditions: Heart Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

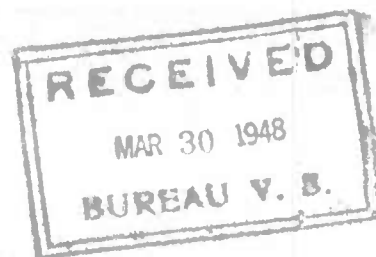
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William R. Humphrey M. D. or otherAddress Rockville, Md. Date signed 3/24/48



MARGIN RESERVED FOR BINL

9-45-15M

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02910

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

### 1. PLACE OF DEATH:

County Montgomery  
City or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 554 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

Street No. R#2  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Osborn Crawford

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948 at 10:25 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 14 1946 to March 1 1948

and that I last saw him alive on March 1 1948

Immediate cause of death

Acute cardiac failure

DURATION

24 hours

Due to Chronic myocarditis

Due to General arteriosclerosis

Other conditions Fractured hip -

Sept. 1946

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Sandy Springs Md.

M. D. or other

Date signed 3/1/48

Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Grace C. Crawford

7. Birth date of deceased (mo., day, yr.) March 3, 1860 6.(c) If alive, give age 47 years

8. AGE: Years 87 Months 11 Days 28 if less than one day hrs. min.

9. Birthplace Unknown white Oak, Md.  
Town, county, and state

10. Usual occupation Unknown - Farmer Retired

11. Industry or business

FATHER 12. Name Unknown  
13. Birthplace Unknown

MOTHER 14. Maiden name Unknown  
15. Birthplace Unknown

16. Informant Hospital records

Address Sandy Springs, Md.

17. Funeral 3-3-48 Date thereof (month) (day) (year)

Cemetery or crematory Collegedale Cem.  
Location Collegedale, Tenn.

18. Funeral director Wm. Parker

Address 4557 Wisconsin Ave. Bethesda Md.

19. 3-1- 1948 Registrar Ext. 15. Lavelle  
(Date rec'd by registrar)

armation carefully. The correct of death clearly and legibly

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item is especially important. Physicians: please write the

RECEIVED

MAR 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

166

02911

Reg. Dist. No. 214

<b>1. PLACE OF DEATH:</b> Country <u>Montgomery</u> City or town <u>Kensington, Md</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Montgomery</u> City or town <u>Kensington</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____			
<b>3. (a) FULL NAME</b> <u>Burton Davis</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Male</u>				<b>5. Color or race</b> <u>Colored</u>			
<b>6. (a) Single, married, widowed, or divorced</b> <u>Single</u>				<b>6. (b) Name of husband or wife</b>			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>March 3, 1926</u>				<b>6. (c) If alive, give age</b> _____ years			
<b>8. AGE:</b> Years <u>22</u> Months _____ Days _____ If less than one day _____ hrs. _____ min.				<b>9. Birthplace</b> <u>Kensington, Md</u> (Town, county, and state)			
<b>10. Usual occupation</b> <u>Radio</u>				<b>11. Industry or business</b>			
<b>MOTHER</b>				<b>FATHER</b>			
<b>12. Name</b> <u>Samuel Davis</u>				<b>13. Birthplace</b> <u>Md</u>			
<b>14. Maiden name</b> <u>Catherine Everest</u>				<b>15. Birthplace</b> <u>Md</u>			
<b>16. Informant</b> <u>Catherine Davis</u>				<b>17. Burial</b> <u>March 24, 1948</u> (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)			
<b>18. Cemetery or crematory</b> <u>Arlington</u>				<b>19. Location</b> <u>Arlington, Va.</u>			
<b>20. Funeral director</b> <u>Robert R. Snodden</u>				<b>21. Address</b> <u>Rockville, Md</u>			
<b>22. Signature</b> <u>Joseph Schaeff</u>				<b>23. Address</b> <u>Yarlington, Md</u>			

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948 at 2:00 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def med exam case 1948 and that I last saw h. alive on 19

Immediate cause of death \_\_\_\_\_

 Due to gun shot wound in epigastrium  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date of 3-20-48Where did injury occur? Kensington Monty Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury shot gun wound Injured at work? no23. SIGNATURE Frank J. Broschart Md. M. D. or otherAddress Yarlington Md Date signed 3-20-48

RECEIVED

MAR 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: Montgomery  
 County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 days  
 Hospital, institution, or street address where death occurred Suburban Hosp  
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State DC County Montgomery  
 City or town Ching Chao  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3515 Patterson St NW  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW

3. (a) FULL NAME Frederick Werten dyke De Mund 3. (b) Social Security Number 057-09-9193

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Ladie Bellinger

7. Birth date of deceased (mo., day, yr.) Mar. 8, 1875 8. (c) If alive, give age 73 years

8. AGE: Years 73 Months 0 Days 22 It less than one day hrs. min.

9. Birthplace New Jersey  
 (Town, county, and state)

10. Usual occupation Real Estate New York City

11. Industry or business City

12. Name of father John de Mund

13. Birthplace New York City

14. Maiden name Christina Werten dyke

15. Birthplace Werten dyke, N. J.

16. Informant John Arthur de Mund

Address Rochester N.Y.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 4/2/48  
 (month) (day) (year)

Cemetery or crematory Valley Cemetery

Location Paramus, N.Y.

18. Funeral director Cheng Chong Funeral Home

Address 5103 Ari Ave N.H.

19. 3/3/ 1948 Registrar W.E. Jones

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 30 1948 at 4:30 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 28 1948 to Mar 30 1948

and that I last saw him alive on Mar 30 1948

Immediate cause of death Coronary occlusion DURATION 3 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John de Mund M. D. or other

Address 6001 Woodch New Date signed Mar 30, 1948

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH

RECEIVED  
APR 2 1948  
BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH  
 2411 N. Charles St., Baltimore

02913

47d

No. G 114 MAR 30 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

 County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 16 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 months, 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 48 I St., N. W., Wash., D.C.  
 (If rural, give LOCATION)

2. (a) If veteran, name War \_\_\_\_\_

## 3. (a) FULL NAME

DESMARIS, Evelyn (n) Dependent

## 3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>W-U.S.</u>	6. (a) Single, married, widowed, or divorced <u>married</u>	
6. (b) Name of husband or wife <u>Joseph M. Desmaris</u>			
7. Birth date of deceased (mo., day, yr.) <u>Dec. 22, 1908</u>			
8. AGE:	Years	Months	Days
	<u>39</u>	<u>32</u>	<u>2</u>
			<u>14</u>
			hrs. min.

 9. Birthplace Washington, D. C.  
 (Town, county, and state)
10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

 12. Name WILLIAMS, James Sex Sex  
 13. Birthplace Texas

 14. Maiden name LOCKHARDT, Ella  
 15. Birthplace Wash., D.C.

 16. Informant husband: Joseph M. Desmaris, PhMlc  
 Address 48 I St., N.W., Wash., D.C.

 17. burial Date thereof 3-10-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

 Cemetery or crematory Arlington National  
Arlington, Virginia  
 Location

 18. Funeral director W.W. CHAMBERS Funeral Home  
 Address 517 11th St. SE, Washington, D.C.

 19. 3-7- 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

 20. DATE OF DEATH March 6 19 48 at 9: P M

 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec. 20 19 47 to March 6 19 48  
 and that I last saw her alive on 6 March 19 48

 Immediate cause of death Carcinoma, Lung.  
 DURATION 10 mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

 Date of op. \_\_\_\_\_  
 Autopsy results Carcinoma, Lung & metastasis  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. T. FOWLER, Jr., M.D. USN
 Address USNH Bethesda, Md. Date signed 3-7-48

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MAR 10 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02914

Reg. Dist. No. 214

### 1. PLACE OF DEATH:

County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 9702 Columbia Blvd  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Herbert Moore Dodd

### 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Alice Ward Dodd

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1881

8. AGE: Years 66 Months 5 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Waterford Va.  
(Town, county, and state)

10. Usual occupation Gov. Clerk. Post office

11. Industry or business

12. Name Joel Dodd.

13. Birthplace Falmouth, Va.

14. Maiden name Katherine Eghtner

15. Birthplace Falmouth, Va.

18. Informant Jessie Lee Kemp

Address 7211 Cobalt Rd. Woodrow, Md.

11. Burial Date thereof 3 6 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory OAKWOOD CEMETERY

Location FALLS CHURCH, VIRGINIA

18. Funeral director S.H. HINES Co.

Address 2901-14-N.W.-Washington, D.C.

19. Mar 3 19 48 Joseph N. Schaeff  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 19 48 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 21 19 43 to March 3 19 48 and that I last saw him alive on March 2 19 48

Immediate cause of death Metastatic Carcinoma

Due to Carcinoma of Rectum

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Includer Carcinoma Date of op. 13 Feb 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Marion Baughhead M.D.

Address 2401 Sutton Rd. Silver Spring, Md. M. D. or other

Date signed 3-3-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contents of this page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02915

Reg. Dist. No. 217

## 1. PLACE OF DEATH

County MontgomeryCity or town Brighton, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death?

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montgomery County MontgomeryCity or town Brighton, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William Dorsey

## 3. (b) Social Security Number

none

## 4. Sex

Male

## 5. Color or race

C

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) April 24, 1851

## 8. AGE:

Years 96Months 11Days 7

It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Howard Co. Md.  
(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

## FATHER

## 12. Name

unknown

## 13. Birthplace

## MOTHER

## 14. Maiden name

Anne Howard

## 15. Birthplace

Howard Co. Md.

## 16. Informant

## Address

## 17.

(Burial, cremation, or removal. Which?)

Date thereof Nov. 18, 1948  
(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

March 18, 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1948 at 4:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 20, 1946 to March 16, 1948  
and that I last saw him alive on March 15, 1948

Immediate cause of death

Coronary Occlusion  
Cardiovascular  
Disease

Due to

Due to

Other conditions Bronchitis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Neely Sewell, M.D.

M. D. or other

Address

Worbeck, Md. Date signed 3-17-48

RECEIVED

MAR 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

02917

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MONTGOMERYCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 1/2 hours

Hospital, institution, or street address where death occurred:

Suburban Hospital 8600 Old Georgetown Road BethesdaHow long in hospital or institution? 4 1/2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County MontgomeryCity or town Rt. 28 #1, Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

BABY GIRL DUVALL "A"

## 3. (b) Social Security Number

4. Sex FEMALE 5. Color or race COLORED 6. (a) Single, married, widowed, or divorced NEWBORN - 6 mos.

8. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) March 28, 19488. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 4 hrs. 23 min.9. Birthplace Bethesda, Md. Co., Maryland  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name UNKNOWN HARRY STEWART13. Birthplace MONT Co., Md.14. Maiden name Hannah Duvall15. Birthplace MONTGOMERY Co., Maryland16. Informant MOTHER - HANNAH DUVALLAddress Gaithersburg, Md. Rt. #117. Cremation Date thereof MARCH 30 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Suburban HospitalLocation 8600 Old Georgetown Rd. BETHESDA, MD18. Funeral director A.B. Salom / suprAddress Bethesda 14 md19. 4-7-48 W.E. Jolly  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 28 1948 at 9:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5:07 P.M. March 28 1948, to March 28 9:40 P.M.and that I last saw her alive on March 28 1948Immediate cause of death Premature

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W.E. Jolly, M.D.

M. D. or other

Address \_\_\_\_\_ Date signed \_\_\_\_\_

RECEIVED

APR 13 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

02916

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County MONTGOMERY  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 1/2 HOURS  
Hospital, institution, or street address where death occurred: Suburban Hospital  
8600 Old Georgetown Road, Bethesda  
How long in hospital or institution? 4 1/2 HOURS

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Montgomery  
City or town RFD #1 Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Baby Girl DUVALL 'B'

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced NEWBORN - 6 MONTHS  
Premature  
6. (b) Name of husband or wife \_\_\_\_\_  
7. Birth date of deceased (mo., day, yr.) March 28, 1948 6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 4 hrs. 32 min.

9. Birthplace Bethesda, Md. Co. Maryland  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name HARRY STEWART

13. Birthplace MONT CO., MD.

14. Maiden name HANNAH DUVALL

15. Birthplace MONTGOMERY Co. Maryland

16. Informant HANNAH DUVALL

Address Gaithersburg, Md. R#1

17. Cremation Date thereof March 30 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Suburban Hospital

Location 8600 Old Georgetown Rd. Bethesda, Md

18. Funeral director A. B. Salom, Supt

Address Bethesda 14, Md

19. 4-7 Registrar W.E. Jones

(Date rec'd by registrar) \_\_\_\_\_

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 19 48 at 9:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5:08 p.m. Mar. 28 19 48 to 7:40 p.m. Mar 28 19 48

and that I last saw him alive on March 28 19 48

Immediate cause of death Premature DURATION \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature W.F. Kessel, M.D.

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

APR 13 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02918

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Emory Grove, Gaithersburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Emory Grove, Gaithersburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Medford  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

E Liza Ann

## 3. (b) Social Security Number

hlurall

## 4. Sex

Female

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Nathan hlurall

## 7. Birth date of deceased (mo., day, yr.)

April 30, 1881

## 6. (c) If alive, give age

68 years

## 8. AGE:

66 Years1 Months12 Days

If less than one day

hrs.

min.

## 9. Birthplace

Montg. Co. Maryland  
(Town, county and state)

## 10. Usual occupation

House keeper

## 11. Industry or business

MOTHER FATHER

## 12. Name

Lawrence Braxton

## 13. Birthplace

Maryland

## 14. Maiden name

Arie Lushett

## 15. Birthplace

md.

## 16. Informant

Nathan hlurall (Widow)

## Address

Emory Grove, Md.

## 17. Burial

(Burial, cremation, or removal, which?)

## Date thereof

March 19, 1948  
(month) (day) (year)

## Cemetery or crematory

Church Cemetery

## Location

Emory Grove, Md.

## 18. Funeral director

R. L. Snowden

## Address

Rockville, Md.

## 19. March 19, 1948

(Date rec'd by registrar)

Abner L. Cooke

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1948 at 8:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 13, 1947 to March 16, 1948and that I last saw him alive on Mar 15, 1948

Immediate cause of death

Cerebral thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Abner L. Cooke

M. D. or other

Address

Gaithersburg

Date signed

March 16, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02919 216

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Rural near Rockville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death... 2 weeks  
 Hospital, institution, or street address where death occurred:  
Waverley Sanitarium  
 How long in hospital or institution... 2 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... D.C. County...  
 City or town... WASHINGTON  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 3046 R ST. N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... ☒

## 3. (a) FULL NAME

Mary Drayer Edson

## 3. (b) Social Security Number

4. Sex... Female 5. Color or race... White 6.(a) Single, married, widowed, or divorced... Widow  
 6.(b) Name of husband or wife... Charles B. Edson  
 7. Birth date of deceased (mo., day, yr.)... August 18th-1868. 6.(c) If alive, give age... years

8. AGE: Years... 79 Months... 7 Days... 13 If less than one day... hrs. ... min.

9. Birthplace... Hartford City, Indiana  
 (Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business... Her home

12. Name... PETER A. DRAYER

13. Birthplace... OHIO

14. Maiden name... MATILDA OLDENATHER

15. Birthplace... OHIO

16. Informant... PETER EDSON

Address... 3046 R ST. WASHINGTON DC

17. BURIAL Date thereof... 4/3/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... ODD FELLOWS CEMETERY

Location... HARTFORD CITY, INDIANA

18. Funeral director... Wm. Ransom Pumpfun

Address... Bethesda, Maryland

19. April 4 19 48 Wm. G. Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 31- 1948 at 9:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27- 1948 to March 31- 1948 and that I last saw her alive on March 31- 1948

Immediate cause of death... Bronchopneumonia-3 days DURATION

Due to...

Due to...

Other conditions... Extremely feeble Unknown

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op. ....

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Wheeler O. Huff-M.D.

Address... Bethesda, Md. Date signed... 3-31-48

RECEIVED

APR 9 1948

BUREAU V. 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02920

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town White Oak Silver Springs R.F.D. #2  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Robert Ellison

## 3. (b) Social Security Number

578-16-3299

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Hattie Ellison

## 7. Birth date of deceased (mo., day, yr.)

October 7, 1880

## 6. (c) If alive, give age..... years

## 8. AGE:

68

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

Culpepper, Va.

(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

## FATHER

## 12. Name

Wash. Ellison

## 13. Birthplace

Va.

## MOTHER

## 14. Maiden name

Nancy Jones

## 15. Birthplace

Va.

## 16. Informant

Hattie Ellison

## Address

Silver Springs Md. R.F.D. #2

## 17. Burial

(Burial, cremation, or removal, Which?)

## Date thereof

March 17, 1948

## Cemetery or crematory

Good Hope

## Location

Colesville Md.

## 18. Funeral director

Robert R. Snowden

## Address

Rockville, Md.

## 19. Date rec'd by registrar

Mar 16 1948Joseph M. Schaeffer

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montgomery County Montgomery  
 City or town White Oak Silver Springs Md. R.F.D. #2  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

## 2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1948 at 3:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946 to March 14 1948 and that I last saw him alive on March 13 1948

## Immediate cause of death

Chronic nephritis

## DURATION

2 years

## Due to.....

## Due to.....

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

C. ProstateDate of op. Mar. 1947

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

## Injured at work?

## 23. SIGNATURE

Calvin B. LeCompte  
Wheaton Md.  
 Address..... Date signed 3/16/48

M. D. or other





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02921

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Olney  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Montgomery County General Hospital Inc.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County \_\_\_\_\_City or town Falls Church Rt #1  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Frank Miller Foster

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteSingle

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 3, 19308. AGE: Years 18 Months 0 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Virginia  
(Town, county, and state)

10. Usual occupation

School

11. Industry or business

12. Name Mr. Cleveland Lee Foster13. Birthplace Virginia14. Maiden name Virginia Miller15. Birthplace Virginia16. Informant Hospital Records

Address

17. Burial Date thereof 3-21-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rockland Cem.Location Rockland, Virginia18. Funeral director Wm. Newton HumphreyAddress Geetha Da Md. J.C.D.H.19. 3-19-48 Gertrude Lawler  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1948 at 4:10 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 29, 1948 to March 19, 1948 and that I last saw him alive on March 19, 1948

Immediate cause of death

Massive hemoptysis

DURATION

1 dayDue to Atypical Virus pneumonia 10 days

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

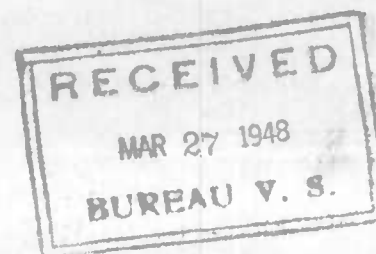
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE \_\_\_\_\_

M. D. or other

Address Sandy Spring, Md Date signed 5/19/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

02922

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr. 5 months  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 yr. & 5 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... D.C. County.....  
 City or town..... Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 526 Edgewood St., N.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... WWI ✓

## 3.(a) FULL NAME

FUSE, Charles John

## 3.(b) Social Security Number

4. Sex..... male  
 5. Color or race..... W-US  
 6.(a) Single, married, widowed, or divorced..... single  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... October 13, 1877  
 8. AGE: Years..... 70 Months..... 5 Days..... 11 If less than one day..... hrs. .... min.

9. Birthplace..... Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation..... unemployed  
 11. Industry or business.....  
 12. Name..... FUSE, Charles J. dec.  
 13. Birthplace..... Md.  
 14. Maiden name..... ROCHE, Nellie dec.  
 15. Birthplace..... Md.

16. Informant..... sister: Mrs. Annie Smith  
 Address..... 526 Edgewood St., N.E., Wash., D.C.  
 17. burial Date thereof..... 3-29-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Arlington National  
Arlington, Va.  
 Location.....  
 18. Funeral director..... W. W. Chambers P.F.K.  
 Address..... 517 11th St., S.E., Wash. D.C.  
 19. 3-25 19 48 Mary C. Patterson  
 (Data rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 24 19 48 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 24 19 46 to March 24 19 48  
 and that I last saw him alive on 24 March 19 48

Immediate cause of death..... Bronchopneumonia DURATION.....  
 Due to..... Coronary Artery Thrombosis not Recent  
 Due to..... arterio-sclerotic Coronary artery disease indef.  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results..... as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... F. E. WETZEL Injured at work?  
 23. SIGNATURE..... F. E. WETZEL, Lt. MC USN M. D. or other  
 Address..... USNH Bethesda, Md. Date signed..... 3-25-48

RECEIVED

MAR 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02923

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County..... **Montgomery**  
 City or town..... **Bethesda (rural)**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **1 month, 12 days**  
 Hospital, institution, or street address where death occurred:  
**US Naval Hospital, Bethesda, Md.**  
 How long in hospital or institution? **1 month, 12 days**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... **D.C.** County.....  
 City or town..... **Washington**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **1527 Q Street, N. W.**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... **WWI** ✓

## 3. (a) FULL NAME

**GIPSON, Alexander**

## 3. (b) Social Security Number

4. Sex..... **male** 5. Color or race..... **Colored** 6.(a) Single, married, widowed, or divorced..... **married**  
 6.(b) Name of husband or wife..... **Emma D. Gipson**  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) **February 16, 1893**  
 8. AGE: Years..... **55** Months..... **0** Days..... **17** If less than one day..... hrs. .... min.

9. Birthplace..... **Tenn.**  
 (Town, county, and state)  
 10. Usual occupation..... **Retired Civil Service**  
 11. Industry or business.....  
 FATHER 12. Name..... **GIPSON, Henry** dec.  
 13. Birthplace..... **Tenn.**  
 MOTHER 14. Maiden name..... **BRYANT, Hattie** dec.  
 15. Birthplace..... **Tenn.**

16. Informant..... **wife: Mrs. Emma D. Gipson**  
 Address..... **1527 Q St., N.W., Wash., D.C.**  
 17. **burial** Date thereof..... **3-8-48**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... **Arlington National**  
 Location..... **Arlington, Va.**  
 18. Funeral director..... **McGuire Funeral Home F.A.P.**  
 Address..... **1820 9th St., N.W., Wash., D.C.**  
 19. **3-3-** 19 **48** **Mary C. Patterson**  
 (Date rec'd by registrar) Registrar

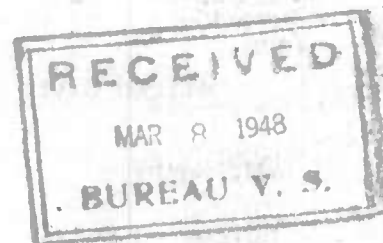
## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **3 March** 19 **48** at **10:02A**  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**21 January** 19 **48** to **3 March** 19 **48**  
 and that I last saw him alive on **3 March** 19 **48**

Immediate cause of death.....  
**Nephritis Chronic** DURATION **1 yr. +**  
**with uremia**  
 Due to **Hypertension, arterial** **1 yr. +**  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results..... **confirmed above**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?  
 23. SIGNATURE..... **A. E. Marland Jr.**  
**A. E. MARLAND, Jr., Lt. JG MC USN**  
 M. D. or other  
 Address..... **USNH Bethesda, Md.** Date signed..... **3-3-48**



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 month, 1 day  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 1 month, 1 day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County Arlington  
City or town Arlington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3414 South Abingdon St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war WWII

### 3. (a) FULL NAME

GORLICK, Julius

### 3. (b) Social Security Number

4. Sex male 5. Color or race Jewish 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Esther Gorlick

6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) March 18, 1923

8. AGE: Years 25 Months 9 Days 0 If less than one day hrs. min.

9. Birthplace New York  
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business War Department

12. Name GORLICK, Ralph

13. Birthplace Russia

14. Maiden name DICKSTEIN, Frieda

15. Birthplace Russia

16. Informant wife: Mrs. Esther Gorlick

Address 3414 So. Abingdon St., Arlington, Va.

17. (Burial, cremation, or removal, Which?) burial

Date thereof Mar. 19, 1948  
(month) (day) (year)

Cemetery or crematory Mt. Hebron Cemetery

Location Brooklyn, N.Y.

18. Funeral director GOLDBERG FUNERAL HOME

Address 4217 9th St., N. W., Wash., D.C.

19. 3-18 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 18 March 19 48 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 February 19 48 to 18 March 19 48

and that I last saw him 18 March 19 48

Immediate cause of death Carcinoma, unspecified

metastatic, generalized

Due to 9 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury war Injured at work?

23. SIGNATURE W. A. DINSMORE, Lt. MC USN

M. D. or other

Address USNH Bethesda, Md.

Date signed 3-18-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 22 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02925

92a

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County..... Montgomery  
 City or town..... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 days  
 Hospital, institution, or exact address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Charles

City or town..... Newburg  
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... Post Office  
 (If rural, give LOCATION)

2.(a) If veteran, name war..... ☒

## 3. (a) FULL NAME

GREEN, John

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

Col.

## 6. (a) Single, married, widowed, or divorced

single

## 8. (b) Name of husband or wife

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... September 1, 1888

## 8. AGE:

Years

Months

Days

If less than one day

59623

hrs.

min.

## 9. Birthplace

Md.

(Town, county, and state)

## 10. Usual occupation

unknown

## 11. Industry or business

## FATHER

## 12. Name

GREEN, Georgedec.

## 13. Birthplace

Md.

## MOTHER

## 14. Maiden name

Celie ?dec.

## 15. Birthplace

unknown

## 16. Informant

brother: Mr. Frank Green

## Address

Newburg, Md. (Charles County)

## 17.

(Burial, cremation, or removal. Which?)

Date thereof.....

3-31-48  
(month) (day) (year)

## Cemetery or crematory

Arlington National

## Location

Arlington, Va.

## 18. Funeral director

W. Ernest Jarvis L.H.

## Address

1432 U St., N. W., Wash., D.C.

## 19.

(Date rec'd by registrar)

3-2648Mary C. Patterson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 24 19 48 at 5:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

22 March 19 48, to 24 March 19 48

and that I last saw him alive on 24 March 19 48

## Immediate cause of death

## DURATION

Arterio valvular  
heart disease  
arterio sclerosis

## Due to

## Due to

## Other condition

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.....

## Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... injured at work?

## 23. SIGNATURE

F. E. WETZEL  
F. E. WETZEL, Lt. MC USN

M. D. or other

Address..... USNH Bethesda, Md. Date signed..... 3-26-48

RECEIVED

APR 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No.

02926

223-

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 months

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospHow long in hospital or institution? 6 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia CountyCity or town Washington, D.C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5417 - 31st St. N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Miss Marion D. Greer

## 3. (b) Social Security Number

Retired

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1889

## 8. AGE:

Years 58Months 2Days 27

If less than one day

hrs. min.

## 9. Birthplace

Rocky Mt., Va.  
(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Thomas Greer

## 13. Birthplace

Rocky Mt. Va.

## 14. Maiden name

Etta Willis

## 15. Birthplace

Calloway Va.

## 16. Informant

Patient's chart and sister

## Address

## 17.

(Burial, cremation, or removal, which)

Date thereof

March 18-1948  
(month) (day) (year)

## Cemetery or crematory

Franklin County

## Location

Rocky Mount - Virginia

## 18. Funeral Director

## Address

1557 W. 21st St. Bethesda Md

## 19.

(Date rec'd by registrar)

19 47Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 19 48 at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12 Sept. 19 47 to 16 March 19 48and that I last saw him alive on 16 March 19 48

Immediate cause of death

Peripheral Circulatory Failure

## DURATION

3 days

Due to

General Toxemia3 months

Due to

Generalized Carcinomatosis3 yrs.

Due to

Carcinoma of Breast4 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Carcinomatosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Russell A. Dunn, M.D.

M. D. or other

Address

Washington San. & Hosp.

Date signed

March 16, 1948

RECEIVED

MAR 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Olney, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

Now long in hospital or institution?

6.6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Sandy Spring  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Beverly Hackett

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored. Single

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

February1978

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

701

hrs.

min.

9. Birthplace

Brookeville, Maryland  
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name

Charles Hackett

13. Birthplace

Brookeville, Maryland

14. Maiden name

Annie Hackett

15. Birthplace

Maryland

16. Informant

Hospital records

Address

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar 19 1948  
(month) (day) (year)

Cemetery or crematory

Sandy Spring

Location

Sandy Spring, Md.

18. Funeral director

Robert P. Snowden

Address

Rockville, Md.

19.

3-18-

19

48 Gertrude B. Lawler

(Date rec'd by registrar)

Registrar

23. SIGNATURE

Robert P. Snowden

M. D. or other

Address

Sandy Spring, Md.

Date signed

3/17/48

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1948 at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 11 1948 to March 17 1948and that I last saw him alive on March 17 1948Immediate cause of death Uremia

DURATION

3 mos

Due to

Hypertensive Cardiac

Due to

vascular disease2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert P. Snowden

M. D. or other

Address

Sandy Spring, Md.

Date signed

3/17/48

RECEIVED

MAR 27 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

02928

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

### 1. PLACE OF DEATH:

County Montgomery  
City or town Rural (ASHTON)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred: Rockville RFD #3, Md.  
How long in hospital or institution? —

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Rural (ASHTON)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. RFD #3, Rockville, Md.  
(If rural, give LOCATION)  
2.(a) If veteran, name war —

### 3.(a) FULL NAME

Richard Wesley Hall

### 3.(b) Social Security Number

4. Sex M 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Willie Ann Hall

7. Birth date of deceased (mo., day, yr.) 7-8-70 6.(c) If alive, give age — years

8. AGE: Years 77 Months 8 Days 13 If less than one day 9 hrs. 20 min.

9. Birthplace Sandy Bottom, md.  
(Town, county, and state)

10. Usual occupation Farmer

### 11. Industry or business

12. Name John Hall  
13. Birthplace Sandy Bottom, md.  
14. Maiden name Grace Virginia Burkett  
15. Birthplace Maryland

16. Informant Richard W. Hall Jr.  
Address Rockville, RFD #3 md.

17. Burial Date thereof 3-25-1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Family Cemetery  
Location Brinklow, Howard Co. md.

18. Funeral director R. L. Snowden  
Address Rockville, md.

19. 3-25 19 48 Gertrude B. Fowler  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 1948 at 5:15 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/15 19 48 to 3/21 19 48  
and that I last saw him alive on 3/20 19 48

Immediate cause of death Acidosis DURATION 28.

Due to Intestinal Obstruction 1 wk.

Due to Carcinoma of Colon ?

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H. Ligon MD M. D. or other —  
Address Sandy Spring, Md. Date signed 3/21/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 27 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: *Montgomery*  
 County.....*Bethesda*  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
*Suburban Hospital*  
 How long in hospital or institution? *1 day*

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....*MD* County.....*Montgomery*  
 City or town.....*Silver Spring Md*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *11-1 midhurst Rd*  
 (If rural, give LOCATION)  
 2(a) If veteran, name war ☒

3. (a) FULL NAME *Ike Allen Harvey*

3. (b) Social Security Number ☒

4. Sex *M* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *W*

6. (b) Name of husband or wife *John William Harvey*

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) *Oct. 6 - 1866*

8. AGE: Years *81* Months *5* Days *13* If less than one day ..... hrs. .... min.

9. Birthplace *Charles City VA*  
 (Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business *Home*

12. Name *Robert H. Allen*

13. Birthplace *Hanover VA*

14. Maiden name *Elizabeth Ann Gress*

15. Birthplace *Charles City VA*

16. Informant *Mrs Sarah H. Harper*

Address *11 midhurst Rd. St. 5th fl.*

17. *Burial* Date thereof *3-21-48*  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Be Mount*

Location *Panola Virginia*

18. Funeral director *Grayson*

Address *5406 11th St NW Wash DC*

19. *3/19* 19*48* *Wm E Jones*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *March 19* 19*48* at *2:15 pm*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Aug 12* 19*47* to *March 19* 19*48*

and that I last saw him alive on *March 19* 19*48*

Immediate cause of death.....

*Acute Cardiac Failure*

Due to.....

*Terminal Bronchopneumonia*

Due to.....

*Generalized Carcinomatosis*

Other conditions *Carcinoma Breast*

*Surgically removed 1946*  
 (Include pregnancy within 8 months of death) *(4/23/46) a.s.*

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? .....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE *Dean H. Harding M.D.*

Address *112 Laurel St NW Wash DC* Date signed *3-19-48*

RECEIVED  
MAR 23 1948  
BUREAU, V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02930

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 616 Buchanan St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI

## 3. (a) FULL NAME

HARVEY, John Beall

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Alice Harvey  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) February 9, 1893  
 8. AGE: Years 55 Months 1 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation unknown  
 11. Industry or business \_\_\_\_\_  
 12. Name HARVEY, John dec.  
 13. Birthplace Md.  
 14. Maiden name WILKINSON, Martha dec.  
 15. Birthplace Wash., D.C.

16. Informant wife: Mrs. Alice Harvey  
 Address 616 Buchanan St., Arlington, Va.  
 17. burial Date thereof 3-12-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director IVES FUNERAL HOME  
 Address 2847 Wilson Blvd., Arl., Va.  
 19. 3-10 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 March 19 48 at 6 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 March 19 48, to 10 March 19 48  
 and that I last saw him alive on 10 March 19 48

Immediate cause of death Thrombosis Coronary artery old & recent DURATION old - by. vent 3  
 Due to Coronary artery disease indef. atherosclerosis

Due to \_\_\_\_\_  
 Other conditions Bilateral hydrothorax  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury F. E. WETZEL Injured at work? \_\_\_\_\_  
 23. SIGNATURE F. E. WETZEL, Lt. MC USN M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 3-10-48

RECEIVED

MAR 13 1948

BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

02931

## CERTIFICATE OF DEATH

Reg. Dist. No. 212

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Boyd's Bldg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?...

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Montg.  
 City or town... Boyd's - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No...  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... World War #1

## 3. (a) FULL NAME

Nathan T. Hebron

## 3. (b) Social Security Number

577-16-6257

4. Sex... male 5. Color or race... col 6. (a) Single, married, widowed, or divorced... single

6. (b) Name of husband or wife... —

7. Birth date of deceased (mo., day, yr.)... Feb 12 1894 6. (c) If alive, give age... years

8. AGE: Years... 54 Months... 1 Days... 16 If less than one day... hrs. ... min.

9. Birthplace... Boyd's, Md  
 (Town, county, and state)

10. Usual occupation... labrer

11. Industry or business

12. Name... Nathan Hebron13. Birthplace... Maryland14. Maiden name... Mollie Turner15. Birthplace... Maryland16. Informant... Nemie TallyAddress... Boyd's mdDate thereof... Mar 31 - 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory... St Marks Boyd'sLocation... Maryland18. Funeral director... Steffe BarberAddress... Springfield md19. Date... Mar 30 1948 Registrar... Mr. C. C. Hilton(Day rec'd by registrar) By Mrs. W. B. H.

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Mar 28 1948 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1948 to 1948and that I last saw him alive on 1948Immediate cause of death... coronary occlusion DURATION 2 hr.

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Dr. J. B. Burchard M. D. M. D. or otherAddress... Yankeeburg md Date signed... 3-28-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 462 X 02932  
 Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery Co.  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since Jan 22-1948  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hosp.  
 How long in hospital or institution? 1 Month

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D.C.  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2120 37th St. N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Mrs Edna Winfrey Hertzog

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife William E. Hertzog  
 6. (c) If alive, give age 47 years  
 7. Birth date of deceased (mo., day, yr.) Oct. 22 18 77  
 8. AGE: Years 70 Months 4 Days 15 If less than one day hrs. min.

9. Birthplace Buckingham Co. Va.  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

FATHER 12. Name Edward Hill  
 13. Birthplace Va.

MOTHER 14. Maiden name Virginia Davis  
 15. Birthplace Va.

16. Informant Sanitarium Records  
 Address

17. Cremation Date thereof 3-10-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Lincoln Am.  
 Location Washington, D.C.

18. Funeral director The St. Johns Co.  
 Address 2901-14th St. N.W.

19. Mar 7 48 Registrar John Dudd  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 48 at 12:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-26 19 47 to 3-7 19 48  
 and that I last saw her alive on March 7 19 48

Immediate cause of death Carcinoma of Cecum  
+ metastases to  
Liver, Mesenteric  
Sigmoid, & pelvic  
Organs.  
 DURATION 8 mo.

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations Cecum  
Liver, Sigmoid Date of op. 9-8-47

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Paul E. East  
 M. D. or other  
 Address 4847- 2nd Ave. Date signed 3-7-48

**RECEIVED**

MAR 10 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 4 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 months, 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Ohio County \_\_\_\_\_  
 City or town Granville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 185 Granville Road, East  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWI

## 3. (a) FULL NAME

HIBBEN, William

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

W-US

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Mary Hibben

## 7. Birth date of deceased (mo., day, yr.)

October 5, 1896

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

51

5

11

hrs.

min.

## 9. Birthplace

Ohio

(Town, county, and state)

## 10. Usual occupation

unemployed

## 11. Industry or business

FATHER

## 12. Name

HIBBEN, James

dec

## 13. Birthplace

Ohio

MOTHER

## 14. Maiden name

LEWIS, Josephine

dec

## 15. Birthplace

Ohio

## 16. Informant

wife: Mrs. Mary Hibben

Address 185 Granville Road, East Granville, Ohio

## 17. (Burial, cremation, or removal. Which?)

burial

Date thereof

Mar 17, 1948

## Cemetery or crematory

## Location

East Granville, Ohio

## 18. Funeral director

W. W. CHAMBERS (John D. Evans)

## Address

Georgetown, D.C.

## 19. (Date rec'd by registrar)

3-16

1948

Mary C. Patterson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 16 March 1948 at 12:25 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
12 January 1948 to 16 March 1948  
 and that I last saw him in alive on 16 March 1948

## Immediate cause of death

Pulmonary Emboli

## DURATION

min.

## Due to

Pulvic Thrombosis

2 days.

## Due to

Carcinoma of Sigmoid

months

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Carcinoma Sigmoid c metastases.

Date of op.

3-2-48

## Autopsy results

Confirmed above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

## Injured at work?

## 23. SIGNATURE

USNH Bethesda, Md.

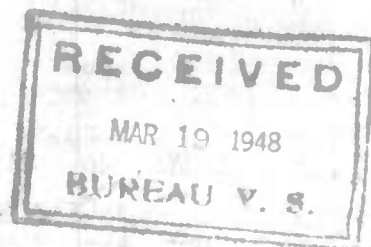
M. D. or other

Address \_\_\_\_\_ Date signed 3-16-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02934

462

Reg. Dist. No. 217

### 1. PLACE OF DEATH:

County Montgomery  
City or town Brinklow  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 86 yrs.  
Hospital, institution, or street address where death occurred:  
Own Home  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Brinklow  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

LEWIS HAMILTON HILL

### 3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Adelaide Saunders Hill  
6. (c) If alive, give age deceased years

7. Birth date of deceased (mo., day, yr.) October 4, 1862

8. AGE: Years 85 Months 5 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Brinklow, Montgomery, Maryland  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Remus Hill

13. Birthplace Ashton, Montgomery, Maryland

14. Maiden name Ruth

15. Birthplace Montgomery, Md.

16. Informant Marie Smith Hill

Address 722 Kenyon St., N.W., Wash., D.C.

17. Burial Date thereof Mar. 20, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Sandy Spring, Md.

Location Sandy Spring, Md.

18. Funeral director Robert P. Schneider

Address Rockville, Md.

19. 3-18-48 Gertrude B. Lawler  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1948 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19, 1948 to March 17, 1948  
and that I last saw him alive on March 16, 1948

Immediate cause of death Coronary occlusion  
Arteriosclerotic Heart Disease  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Partial Obstruction  
to Carcinoma of Cecum.  
(Include pregnancy within 9 months of death)  
Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles H. Lion  
Sandy Spring, Md. M. D. or other \_\_\_\_\_  
Date signed 3/17/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**  
MAR 27 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02935

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda, (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1428 R St., N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI

## 3. (a) FULL NAME

HJORTSBERG, Alexander Lewis

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Mary Hjortsberg  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) August 25, 1884  
 8. AGE: Years 63 Months 6 Days 22 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace N.Y.  
 (Town, county, and state)  
 10. Usual occupation Retired Marine Corps  
 11. Industry or business \_\_\_\_\_  
 FATHER 12. Name HJORTSBERG, Henry dec.  
 13. Birthplace N.Y.  
 MOTHER 14. Maiden name LABARGE, Rose dec.  
 15. Birthplace N.Y.

16. Informant wife: Mrs. Mary Hjortsberg  
Richmond Hill  
 Address 104 46th 111th St., N.Y.  
 17. burial Date thereof 3-22-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
Arlington, Va.  
 Location \_\_\_\_\_  
 18. Funeral director Lee Funeral Home F.H.P.  
 Address 4th & Mass., Avenue, Wash. D.C.  
Mary C. Patterson  
 19. 3-18 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 17 March 1948, at 6:50 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
6 March 1948, to 17 March 1948  
 and that I last saw him alive on 17 March 1948  
 Immediate cause of death Hemorrhage Gastro Intestinal  
 DURATION 24 hrs.  
 Due to Ulcer, Stomach Indef.  
 Due to \_\_\_\_\_  
 Other conditions Primary atypical Pneumonia 10 days  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE H.R. COOPER, Lt. MC USN  
 M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 3-18-48

RECEIVED

MAR 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County **Montgomery**  
 City or town **Bethesda (rural)**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **1 mon. 7 days**  
 Hospital, institution, or street address where death occurred:  
**US Naval Hospital, Bethesda, Md.**  
 How long in hospital or institution? **1 mon. 7 days**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State **D.C.** County .....  
 City or town **Washington**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **457 G Street, S. W.**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war **WWI**

## 3. (a) FULL NAME

**HOLLIS, James Henry**

## 3. (b) Social Security Number

4. Sex **male** 5. Color or race **W-US** 6.(a) Single, married, widowed, or divorced **divorced**  
 6.(b) Name of husband or wife **Edith M. Hollis**  
 7. Birth date of deceased (mo., day, yr.) **December 31, 1891** 6.(c) If alive, give age ..... years  
 8. AGE: Years **56** Months **2** Days **0** If less than one day ..... hrs. .... min.

9. Birthplace **Washington, D.C.**  
 (City, county, and state)  
 10. Usual occupation **Bar Tender**  
 11. Industry or business

FATHER 12. Name **HOLLIS, James Henry** dec. 13. Birthplace **Pennsylvania**  
 MOTHER 14. Maiden name **CLEARY, Florence** dec. 15. Birthplace **Va.**

16. Informant **son: Mr. James H. Hollis III**  
 Address **608 Maryland Avenue, S.W., Wash., D.C.**  
 17. **burial** Date thereof **3-3-48**  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory **Arlington National**  
 Location **Arlington, Va.**

18. Funeral director **Robert A. Mattingly W.L.D.**  
 Address **131 11th St., S.E., Wash. D.C.**  
 19. **3-1** 19 **48** **Mary C. Patterson**  
 (Date rec'd by registrar) Registrar

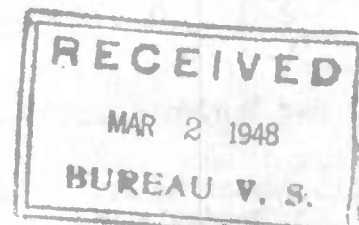
## MEDICAL CERTIFICATION

2D. DATE OF DEATH **1 March** 19 **48**, at **2:30 A.M.**  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **24 January** 19 **48**, to **1 March** 19 **48**  
 and that I last saw him alive on **1 March** 19 **48**

Immediate cause of death **Broncho Pneumonia** DURATION **48 hrs.**  
 Due to **Carcinoma of pancreas with widespread metastases** **1 yr.**  
 Due to .....  
 Other conditions **Arteriosclerosis, generalized, 5 yrs.**  
**moderate**  
 (Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. ....  
 Autopsy results **confirmed above**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury **W. F. Harrison** Injured at work?  
 23. SIGNATURE **W. F. HARRISON Lt. MC USN** M. D. or other  
 Address **USNH Bethesda, Md.** Date signed **3-1-48**





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02937

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County..... **Montgomery**  
 City or town..... **Bethesda (rural)**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... **2 months**  
 Hospital, institution, or street address where death occurred:  
**US Naval Hospital, Bethesda, Md.**  
 How long in hospital or institution?..... **2 months**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... **D.C.** County.....  
 City or town..... **Washington**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... **229 A Bates St., N.W.**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... **Sp.American War** ✓

## 3. (a) FULL NAME

**HOWARD, Bert**

## 3. (b) Social Security Number

4. Sex..... **male** 5. Color or race..... **W-US** 6.(a) Single, married, widowed, or divorced..... **married**  
 6.(b) Name of husband or wife..... **Helen Howard**  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... **December 17, 1882**  
 8. AGE: Years..... **65** Months..... **2** Days..... **25** If less than one day..... hrs. .... min.

9. Birthplace..... **Washington, D.C.**  
 (Town, county, and state)  
 10. Usual occupation..... **Retired Civil Service**  
 11. Industry or business.....  
 FATHER 12. Name..... **HOWARD, James Albert** **dec.**  
 13. Birthplace..... **Wash., D.C.**  
 MOTHER 14. Maiden name..... **FRANCE, Rebecca** **dec**  
 15. Birthplace..... **Md.**

16. Informant..... **wife: Mrs. Helen Howard**  
 Address..... **229 A Bates St., N. W., Wash., D.C.**  
 17. **burial** Date thereof..... **3-16-48**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... **Arlington National**  
 Location..... **Arlington, Va.**  
 18. Funeral director..... **W. W. CHAMBERS**  
 Address..... **1400 Chapin St., N.W., Wash., D.C.**  
 19. **3-12** **48** **Mary C. Patterson**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **12 March** 19 **48** at **5:45 A.M.**  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**12 January** 19 **48** to **12 March** 19 **48**  
 and that I last saw h. **1m** alive on **12 March** 19 **48**  
 Immediate cause of death..... **Carcinoma, esophagus with metastasis** DURATION..... **6 mons.?**  
 Due to.....  
 Due to.....  
 Other conditions..... **Pneumonitis right upper lobe, terminal** days ?  
 (Include pregnancy within 3 months of death)  
 Major findings of operations..... **exploratory thoracotomy** Date of op. **2-10-48**  
 Autopsy results..... **confirmed above**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... **R. N. Shelley** Injured at work?  
 23. SIGNATURE..... **R. N. SHELLEY, Cdr. MC USN** M. D. or other  
 Address..... **USNH Bethesda, Md.** Date signed..... **3-12-48**

RECEIVED

MAR 13 1948

BUREAU V. S.



RECEIVED

MAR 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02939 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington, D.C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2916 S St., S.E.  
 (If rural, give LOCATION)  
Sp. Am.  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

ISAKSEN, Isak

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, or divorced widowed  
 6. (b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) 31 March 1877 8. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 70 Months 11 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Norway  
 (Town, county, and state)  
 10. Usual occupation Retired Navy  
 11. Industry or business \_\_\_\_\_

12. Name ISAKSEN, Pedar dec.  
 13. Birthplace Norway  
 14. Maiden name CHRISTENSEN, Marie dec.  
 15. Birthplace Norway

16. Informant son: Mr. John Isaksen  
 Address 2916 S St., S.E., Wash., D.C.

17. burial Date thereof 4-1-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory CEDAR HILL  
 Location Washington, D.C.

18. Funeral director W. W. CHAMBERS  
 Address 517 11th St., S.E., Wash., D.C.  
3-29 48 Mary E. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 28 March 19 48 at 3:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 March 19 48 to 28 March 19 48  
 and that I last saw him alive on 28 March 19 48

Immediate cause of death Sub-acute Bacterial endocarditis & terminal Broncho pneumonia  
 Due to Syphilitic aortic valvulitis indef  
 Other conditions \_\_\_\_\_

Major findings of operations \_\_\_\_\_  
 (Include pregnancy within 8 months of death)  
 \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accidental, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 (Injured at home, farm, industry, public place (where?))  
 Manner of injury \_\_\_\_\_ (Injured at work?)

23. SIGNATURE F. E. WETZEL, Lt. MC USN  
USNH Bethesda, Md.  
 Address \_\_\_\_\_ Date signed 3-29-48

**RECEIVED**

MAR 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02940

Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County MontgomeryCity or town Patuxent  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Patuxent  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George Jackson

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 10, 1876

8. AGE:

Years

Months

Days

If less than one day

72 1 18 hrs. min.

9. Birthplace

Capitol Heights, Md.  
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Unknown

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Welfare Board  
Rockville, Md.17. Burial  
(Burial, cremation, or removal, Which?)Date thereof March 23, 1948  
(month) (day) (year)

Cemetery or crematory

Union Wesleyan  
Potomac, Md.

Location

R. L. Snider

18. Funeral director

Rockville, Md.19. 3-23  
(Date rec'd by registrar)19 48EP Thompson  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 48 at ? A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept med exam case 19 48 to 19 48  
and that I last saw him alive on 19 48

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

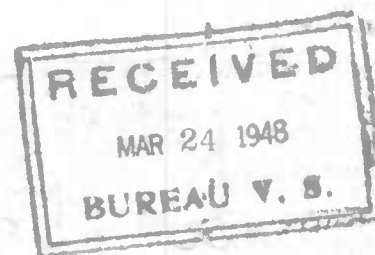
Means of injury Injured at work?

23. SIGNATURE

Frank J. Bronckart M.D.  
Sept med exam M. D. or other  
Yardley, Md. Address Date signed 3-20-48

## DURATION

Found dead in the home





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02941

Reg. Dist. No. 212

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Dickerson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 26 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montg.  
 City or town Dickerson  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sora Margaret Jamison

## 3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Charles C Jamison

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct 8 - 1871

8. AGE: Years 76 Months 6 Days 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Dickerson, Montg. Co. Md.  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Abraham S. Harris13. Birthplace Maryland14. Maiden name Mary Taylor15. Birthplace Ireland16. Informant Charles H. JamisonAddress Dickerson, Md.17. Burial Date thereof 3/10/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Mary'sLocation Barnesville, Md.18. Funeral director William B. HiltonAddress Barnesville, Md.19. March 9 19 48 Mr. C. C. Hilton  
(Date filed by registrar) By Mr. W. B. H. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 19 48 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 19 48 to March 4 19 48  
 and that I last saw him alive on Mar 7 19 48

Immediate cause of death Cerebral Hemorrhage DURATION 4 days  
Cerebral Arteriosclerosis UNK

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Coronary Artery UNK  
disease Myocarditis

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. B. Adams, M.D. M. D. or other \_\_\_\_\_Address Poolesville, Md. Date signed 3/9/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02942

Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Rockville - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 yrs  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery  
 City or town... Rockville and T. Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ada Johnson

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Joseph Johnson  
 7. Birth date of deceased (mo., day, yr.) August 23, 1885-  
 6.(c) If alive, give age 69 years  
 8. AGE: Years 62 Months 6 Days 7 It less than one day  
 hrs. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace... Va  
(Town, county, and state)10. Usual occupation... Housewife

11. Industry or business \_\_\_\_\_

12. Name Isaac Payne13. Birthplace Va14. Maiden name Sarah (unknown)15. Birthplace Va16. Informant Joseph JohnsonAddress Rockville, Md. R.F.D.17. Burial Date thereof March 7, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rocky HillLocation Clarksburg, Md.18. Funeral director Robert R. StoydenAddress Rockville, Md.19. March 7th 19 48 John E. P. Thompson  
(Date rec'd by registrar) (Signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 3 19 48 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Medical Exam caseand that I last saw him alive on March 19

Immediate cause of death \_\_\_\_\_

## DURATION

Cerebral hemorrhage1 hr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

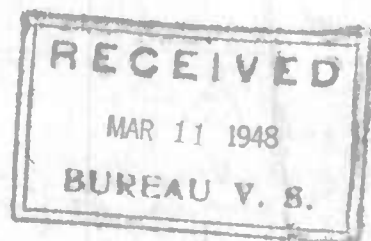
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature Frank J. Prochant M.D.23. SIGNATURE Dep. med. Exam M. D. or otherAddress Clarksburg, Md. Date signed 3-4-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02943

184

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Sandy Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 Years  
 Hospital, institution, or street address where death occurred:  
Montgomery County General Hospital  
 How long in hospital or institution? None - Dead On Arrival

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Silver Spring, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.F.D. # 1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War II

## 3. (a) FULL NAME

William Leroy Jones

## 3. (b) Social Security Number

577-18-6245

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Dorothy Louise Jones  
 6. (c) If alive, give age 20 years  
 7. Birth date of deceased (mo., day, yr.) January 17, 1921  
 8. AGE: Years 27 Months 2 Days 10 If less than one day  
 hrs. min.

9. Birthplace Alexandria, Virginia  
 (Town, county, and state)  
 10. Usual occupation Plumber  
 11. Industry or business None

12. Name Wade H. Jones  
 13. Birthplace Silver Spring, Maryland  
 14. Maiden name Anna V. Kerns  
 15. Birthplace Virginia

16. Informant Mr. Wade H. Jones  
 Address R.F.D. # 1, Silver Spring, Md.  
 17. Burial Date thereof March 30, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Grace Church Cemetery  
 Location Woodside, Maryland

18. Funeral director Wm. Ransom Humphrey  
 Address Bethesda, Maryland

19. Mar 29 48 Gertrude B Lawler  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1948 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dep med Exam case  
 and that I last saw h. alive on 19 10 19  
 Immediate cause of death

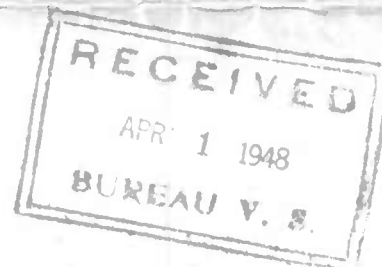
Hemorrhage  
bullet wound thru  
heart (accidental)  
fatal instantly  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide accident Date of 3-27-48  
 Where did injury occur? Calverville Mont Md  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) home  
 Means of injury fatal shot Injured at work? no

23. SIGNATURE Frank J. Brockett M.D.  
Dep med Exam M. D. or other  
Yairshakung Md Date signed 3-28-48



RECEIVED

APR 1 1948

BUREAU V. S.



RECEIVED

MAR 10 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02945

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution? 13 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1104 57th Avenue, N. E.  
(If rural, give LOCATION)2. (a) If veteran, name war WWI

## 3. (a) FULL NAME

LA MOTHE, Theodore

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Florence LaMothe

7. Birth date of deceased (mo., day, yr.)

January 21, 1894

8. AGE:

Years

54

Months

1

Days

24

If less than one day

..... hrs. .... min.

9. Birthplace La.  
(Town, county, and state)10. Usual occupation Civil Guard11. Industry or business Government12. Name LA Mothe, Raphael dec.13. Birthplace La.14. Maiden name GRADENIGO, Bertha dec.15. Birthplace La.16. Informant wife: Mrs. Florence LaMotheAddress 1104 57th Avenue, N.E., Wash., D.C.17. burial Date thereof 3-18-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director W. Ernest JarvisAddress 1432 U St., N.W., Wash., D.C.19. 3-16 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 15 March 19 48 at 6:45 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
2 March 19 48 to 15 March 19 48  
and that I last saw him alive on 15 March 19 48

Immediate cause of death

Pulmonary embolization

Due to

Auricular Thrombosis

Due to

Flutter Fibrillation  
Hypertensive Heart disease  
with congestive failure

Other conditions (Include pregnancy within 8 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

Confirmed Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. DURNING, Lt. JG MC USNR

M. D. or other

Address USNH Bethesda, Md. Date signed 3-16-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 18 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131A

02946

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH: Montg Co.  
County..... Gaithersburg Md, (Rural)  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 yrs 5 Mo  
Hospital, institution, or street address where death occurred:  
Asbury Methodist Home  
How long in hospital or institution? 4Yr 5 Mo,

2. USUAL RESIDENCE (HOME) OF DECEASED  
(For new-born infants give residence of mother)  
State..... Md..... County..... Mont.  
City or town..... Gaithersburg (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
Nannie Parran Linthicum

3. (b) Social Security Number

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Single
------------------	---------------------------	---

6.(b) Name of husband or wife.....  
6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.) Oct 18th 1857  
8. AGE: Years Months Days If less than one day  
1857 90 5 10 hrs. min.

9. Birthplace..... Arundle Co, Md,  
(Town, county, and state)  
10. Usual occupation..... School Teacher, (Retired)  
11. Industry or business.....  
12. Name..... John Linthicum  
13. Birthplace..... Md.  
14. Maiden name..... Ann Matilda Dore  
15. Birthplace..... Md,

16. Informant..... Methodist Home, H. M. Wilson  
Address..... Gaithersburg Md,  
Burial 3/30/48  
(Burial, cremation, or removal. Which?) Date thereof.....  
(month) (day) (year)  
Cemetery or crematory..... Loudon Park Cemetery  
Location..... Baltimore Md,  
18. Funeral director..... Ernest C Gartner  
Address..... Gaithersburg Md,

19. March 29 1948 Abner G Cooke  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 28/48..... 19..... at 2:40A M  
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
Feb-28-1948 to March-28-1948  
and that I last saw her alive on March-27-1948  
Immediate cause of death..... Infarction of heart  
age -  
Due to..... Infarction of heart 1 month  
Due to..... Pneumothorax rupture 1 month  
Other condition..... Arterio-sclerosis  
(Include pregnancy within 8 months of death)

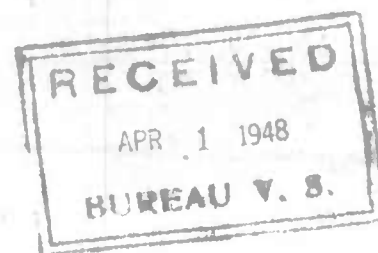
Major findings of operations.....  
Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?).....  
Means of injury..... Injured at work?  
23. SIGNATURE..... William C. Miller, M.D.  
Address..... Gaithersburg, Md Date signed..... 3/29/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH

County Montgomery  
 City or town Silver Spring (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? nine Years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Silver Spring (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James M. Marlow

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Julius B Marlow

## 7. Birth date of

deceased (mo., day, yr.)

Feb 6th 1888

## 6.(c) If alive, give age \_\_\_\_\_ years

64

## 8. AGE:

1888

## Years

60

## Months

1

## Days

10

## If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Maryland  
(Town, county, and state)

## 10. Usual occupation

House Wife

## 11. Industry or business

Henry Musser

## FATHER

## 12. Name

Md,

## 13. Birthplace

Mary E Burdett

## MOTHER

## 14. Maiden name

Md

## 15. Birthplace

## 16. Informant

Julius B. Marlow

## Address

Silverspring, Md, (Rural)

## 17.

(Burial, cremation, or removal. Which?)

Burial

## Date thereof

3/20/48

(month) (day) (year)

## Cemetery or crematory

Neelsville Cemetery

## Location

Germantown Md,

## 18. Funeral director

Ernest C Gartner

## Address

Gaithersburg Md,

## 19.

(Date rec'd by registrar)

March 18 48 Aluida Y Cooke

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 16 1948 at 9:00 A M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Exam case 19\_\_\_\_ to 19\_\_\_\_  
 and that I last saw him alive on 19\_\_\_\_

## Immediate cause of death

Asphyxia by  
strangulation  
(suicide)

## DURATION

Found  
dead  
in home

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 3-16-48Where did injury occur? Silver Spring Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury hanging Injured at work?

## 23. SIGNATURE

Frank J. Buschard M.D

M. D. or other

Address Gaithersburg Md Date signed 3-16-48

**RECEIVED**

MAR 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02948

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 yrs.

Hospital, institution, or street address where death occurred

How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. R # 3 - Oakdale

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Oscar M. Martin

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Barbara Martin

7. Birth date of deceased (mo., day, yr.)

9/26/18806. (c) If alive, give age 56 years

## 8. AGE:

Years

Months

Days

If less than one day

6762

hrs.

min.

## 9. Birthplace

Pa.

(Town, county, and state)

## 10. Usual occupation

Manager

## 11. Industry or business

Same

MOTHER FATHER

## 12. Name

Charles W. Martin

## 13. Birthplace

Pa.

## 14. Maiden name

Emma Ella Barfoot

## 15. Birthplace

Pa.

## 16. Informant

Mrs. Barbara Martin

## Address

Rockville R # 10

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

3/301948

(month) (day) (year)

## Cemetery or crematory

Palmer

## Location

Brookville rd

## 18. Funeral director

Ray W. Barber

## Address

Wheatonville md

## 19. 3-30

(Date rec'd by registrar)

19. 48

Gertrude B. Lander

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28/ 1948, at 6 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/1/ 1948, to 3/28/ 1948and that I last saw him alive on 3/28/ 1948

Immediate cause of death

Cardiac Failure

DURATION

5 hrs.

Due to

Coronary Occlusion29 hrs.

Due to

Other conditions

Hypertension2

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —

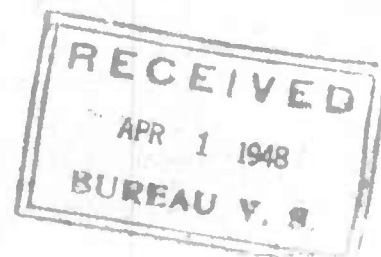
23. SIGNATURE

W. B. Bind

M. D. or other

Address

Shady Spring MdDate signed 3/29/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of given names of deceased and wife MARYLAND STATE DEPARTMENT OF HEALTH

shown on:

2411 N. Charles St., Baltimore

02949

HLM No. G 11 MAR 17 1948 CERTIFICATE OF DEATH

Reg. Dist. No. ~~217~~ 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:  
a US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County

City or town Falls Church  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 E. Greenway Blvd.  
(If rural, give LOCATION)

2. (a) If veteran, name war Mexican Border Ex.

3. (a) FULL NAME

MAXWELL, Deane Dean/Clarence

3. (b) Social Security Number

4. Sex

male

5. Color or race

W-US

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Mary A. Alice Maxwell

7. Birth date of deceased (mo., day, yr.) January 18, 1883  
6. (c) If alive, give age years

8. AGE: Years 65 Months 1 Days 17 It less than one day  
hrs. min.

9. Birthplace Ill.  
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business

12. Name MAXWELL, John dec.

13. Birthplace Tenn.

14. Maiden name HAYES, Mary dec.

15. Birthplace Ohio

16. Informant wife: Mrs. Alice Maxwell

Address 112 E. Greenway Blvd., Falls Church, Va.

17. burial Date thereof 3-8-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. CHAMBERS

Address Georgetown, D.C.  
Mary C. Patterson

19. 3-5 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 March 19 48 at 11:07A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 Feb. 19 48 to 5 March 19 48  
and that I last saw h. in alive on 5 March 19 48

Immediate cause of death Pneumonia, Broncho

Due to Thrombosis Coronary artery

Due to arteriosclerotic coronary artery disease

Other condition pulmonary edema

Rt. Hydrothorax  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results PS - ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury F. E. WETZEL Injured at work?

23. SIGNATURE F. E. WETZEL, Lt. MC USN  
M. D. or other

Address USNH Bethesda, Md. Date signed 3-5-48

RECEIVED

MAR 10 1945

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02950

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 15 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 15 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4207 Tuscany Court,  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Julian Hilleary MAYNARD, Commander USN Retired Inactive

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Rae Maynard

7. Birth date of deceased (mo., day, yr.) June 6, 1887 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 60 Months 9 Days 17 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Retired Navy

11. Industry or business \_\_\_\_\_

FATHER 12. Name MAYNARD, Richard D. dec. 13. Birthplace Ill.

MOTHER 14. Maiden name HILLEARY, Mary dec. 15. Birthplace Md.

16. Informant wife: Mrs. Rae Maynard  
Address 4207 Tuscany Court, Baltimore, 10, Md.

17. burial Date thereof March 25, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory St. Thomas Cemetery  
Baltimore, Md.  
Location \_\_\_\_\_

18. Funeral director STEWART & MOWEN CO - F.M.W.  
Address 108 W. North Avenue, Baltimore, Md.

19. 3-24 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1948 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med Exam Case 19 \_\_\_\_\_  
and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Fracture of skull and multiple fractures of body and limbs  
Due to (suicide)  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
Autopsy results Multiple extreme. Fracture of skull and injuries  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide suicide Date of 3-23-48  
Where did injury occur? Bethesda Montgomery Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury Injured from Hypertension Injured at work? no

23. SIGNATURE Frank J. Borschart M.D. M. D. or other Dep. med. Exam  
Address Yairshewsky Md. Date signed 3-23-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 26 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02951

## CERTIFICATE OF DEATH

Reg. Diat. No. 218

## 1. PLACE OF DEATH:

County Montg Co.  
 City or town Gaithersburg Md (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2yrs 6 Mo.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Gaithersburg Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Eugene A. McAtee

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 11 1856  
 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 91 Months 11 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Boysd. Md.  
 (Town, county, and state)

10. Usual occupation Retired Farmer

## 11. Industry or business

12. Name John McAtee  
 13. Birthplace Md.  
 14. Maiden name Annie A Umstead  
 15. Birthplace Md.

16. Informant Paul Burdett  
 Address Germantown Md.

17. Burial Burial Date thereof 4/1/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Rose Cemetery  
Gaithersburg Md. (Clopper)  
 Location \_\_\_\_\_

18. Funeral director Ernest C Gartner  
 Address Gaithersburg Md.

19. March 30 1948 Alfred S. Corke  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 29th 48 8 30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 1948 to March 29 1948  
 and that I last saw him alive on March 23, 1948

Immediate cause of death acute dilatation of heart suddenly  
 DURATION

Due to chronic myocarditis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE J. P. Harten, M.D.  
Rockville, Md. M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 3/30/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 months, 18 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 2 months, 18 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2610 Stanton Road, S.E.  
(If rural, give LOCATION)  
2. (a) If veteran, name war WWII

### 3. (a) FULL NAME

Methuslah McIVER

### 3. (b) Social Security Number

4. Sex male 5. Color or race Col 6. (a) Single, married, widowed, or divorced single  
8. (b) Name of husband or wife \_\_\_\_\_  
8. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) September 1, 1915  
8. AGE: Years 32 Months 6 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH 29 March 19 48 at 1:25 AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 January 19 48 to 29 March 19 48  
and that I met and saw him alive on 29 March 19 48

Immediate cause of death Pericarditis, chronic DURATION 5 mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Pneumonia type unknown - mss - 47 ill since  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results none obtained Date of op. \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury F.E. WETZEL injured at work?

23. SIGNATURE F. E. WETZEL, Lt. MC USN M. D. or other \_\_\_\_\_

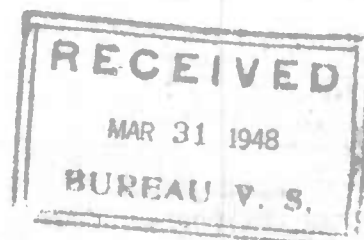
Address USNH Bethesda, Md. Date signed 3-29-48

9. Birthplace N.C. (Town, county, and state)  
10. Usual occupation Army Engineer, Laborer  
11. Industry or business Walter Reed Hospital (civil Service)  
12. Name McIVER, Joseph  
13. Birthplace N.C.  
14. Maiden name LITTLE, Daisy  
15. Birthplace N.C.  
16. Informant mother: Mrs. Daisy McIver  
Address 2610 Stanton Road, S.E., Wash., D.C.  
17. burial Date thereof 3-31-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Virginia  
18. Funeral director Robert G. Mason  
Address 2500 Nichols Avenue, S.E., Wash., D.C.  
19. 3-29 19 48 Mary G. Patterson  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 014

### 1. PLACE OF DEATH:

County MONTGOMERY  
City or town SILVER SPRING, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 days  
Hospital, institution, or street address where death occurred:  
708 SHILOH AVENUE  
How long in hospital or institution? 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3110-18th STREET N.W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war No.

### 3. (a) FULL NAME

OSCAR HENRY MEWHORTER

### 3. (b) Social Security Number

718-10-5310

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife MAGGIE MEWHORTER

6. (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) July 21, 1873

8. AGE: Years 74 Months 8 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace CAHOUN GEORGIA  
(Town, county, and state)

10. Usual occupation CHERICAL WORKER

11. Industry or business RET. SOUTHERN RAILROAD

12. Name Robert Higon MEWHORTER

13. Birthplace ALABAMA

14. Maiden name FRANCIS ME DANIEL

15. Birthplace Georgia

16. Informant J.H. MEWHORTER

Address 21 Philadelphia Ave Takoma Park

17. Burial (Burial, cremation, or removal. Which?) BURIAL Date thereof MARCH 29, 1948  
(month) (day) (year)

Cemetery or crematory Rock CREEK

Location Washington, D.C.

18. Funeral director A. W. Niles Co.

Address 2901-14th Street N.W. Wash D.C.

19. Mar. 26, 1948 Joseph R. Schaeff Registrar

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1948 at 11 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1948 to March 25, 1948 and that I last saw him alive on March 25, 1948

Immediate cause of death Acute Cardiac Failure

Due to Arteriosclerotic Hypertensive Cardiovascular Disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dean H. Harding M.D. M. D. or other \_\_\_\_\_

Address 113 Carroll St NW Date signed 3-25-48

Wash DC

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 29 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington San. and HospitalHow long in hospital or institution? 27 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 10003 Renfrew Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Robert H. Megarry

## 3. (b) Social Security Number

084-03-9413

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Helene Megarry

7. Birth date of

deceased (mo., day, yr.)

Nov. 29, 1903

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

44322

hrs.

min.

9. Birthplace

New York, New York

(Town, county, and state)

10. Usual occupation

Electrical Sales Manager

11. Industry or business

Sun Electric Corp. Chicago.

FATHER

12. Name

James Megarry

13. Birthplace

Ireland

MOTHER

14. Maiden name

Mary Gaw

15. Birthplace

Ireland

16. Informant

Mrs Helene I. Megarry

Address

10,003 Renfrew Rd. Silver Spring

17.

Removal

Date thereof

March 23, 48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Burr Davis Funeral Home

Location

Mt. Vernon, New York

18. Funeral director

Wm E. Humphrey

Address

8434 Ga. Ave., Silver Spring, Md.

19.

March 22, 1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948 at 7:22 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-9-1945to 3/211948

and that I last saw him alive on

3-21-1948

Immediate cause of death

Hematemesis

DURATION

26 hours

Due to

Ruptured Esophageal Varices36 hours

Due to

Cirrhosis of Liver5 years

Other conditions

Obesity -  
Chronic Alcoholism10 years10 years

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Humphrey

M. D. or other

Address

8105 Woodbury Drive

Date signed

3/22/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 24 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 83a 02955 245

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

217 Spring Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 217 Spring Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MAUDE ENCLER MOHR

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

May 30, 1885

## 8. AGE:

Years

Months

Days

If less than one day

62

hrs. min.

## 9. Birthplace

Ohio

(Town, county, and state)

## 10. Usual occupation

At home

## 11. Industry or business

## FATHER

## 12. Name

William Engler

## 13. Birthplace

Ohio

## MOTHER

## 14. Maiden name

Emma M. Crockett

## 15. Birthplace

Ohio

## 16. Informant

Mr. Robert E. Mohr, (Son)

## Address

217 Spring Ave., Takoma Park, Md.

## 17.

CremationDate thereof March 15, 1948  
(month) (day) (year)

(Burial, cremation, or removal. Which?)

## Cemetery or crematory

Fort Lincoln Cemetery

## Location

3201 Bladensburg Rd.

## 18. Funeral director

Chung Chase Funeral Home

## Address

5103 Wis., Ave., N.W.

## 19.

Isaac 16 48 Janus Servis  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 48, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 10 19 48, to March 13 19 48and that I last saw her alive on March 10 19 48

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 days

Due to

Arterial Hypertension

Many

years

Due to

Other conditions

Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Not done

Date of op.

Autopsy results

Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

L.B. Snow M.D.L.B. Snow M.D.

23. SIGNATURE

M. D. or other

Address

914 Sligo Avenue  
Silver Spring, Md.Date signed 3-14-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

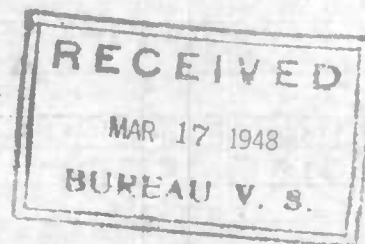
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T

222 N. Charles St.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 266

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Hobbsville Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Hobbsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7209 Cobalt Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Florence Gertrude Monroe

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife George Edmund Monroe

7. Birth date of deceased (mo., day, yr.) Feb. 4 1882  
 6. (c) If alive, give age 65 years

8. AGE: Years 66 Months 1 Days 26 If less than one day  
 ....hrs. ....min.

9. Birthplace Waterbury Connecticut  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Charles Mitchell13. Birthplace England14. Maiden name Bushy15. Birthplace England16. Informant George Edmund MonroeAddress 7209 Cobalt Road17. Burial Date thereof 4-2-1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pinegrove CemeteryLocation Waterbury Connecticut18. Funeral director The S. H. Hines Co.Address 2901 - 14th St Washington D.C.19. 3/30 1948 H. E. Gray

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948 at 3:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Aug. 23 1946 to March 30 1948  
 and that I last saw h.e. alive on March 30 1948.

Immediate cause of death Cerebral hemorrhage  
Generalized arteriosclerosis  
with hypertension  
heart disease

Due to Diabetes mellitus  
 DURATION 3 days  
12 years  
13 years

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

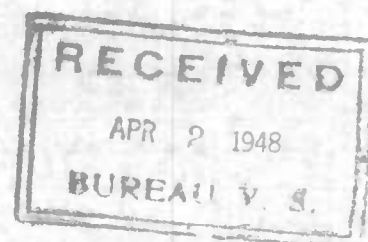
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE C. P. Ryland M.D.

Address 4401 Mass Ave NW M. D. or other  
Wash. D.C. Date signed 3-30-48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

## CERTIFICATE OF DEATH

02957

Reg. Dist. No. 214

### 1. PLACE OF DEATH:

County... MONTGOMERY

City or town... KENSINGTON  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... MONTGOMERY

City or town... KENSINGTON  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 11101 WEST AVE  
(If rural, give LOCATION)

2.(a) If veteran, name war...

### 3.(a) FULL NAME

RUTH ANNE MORRIS

### 3.(b) Social Security Number

577-01-9032

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

FLOYD P.

7. Birth date of deceased (mo., day, yr.)

Jan. 15, 1917

8. AGE: Years Months Days If less than one day

31

3

7

hrs.

min.

9. Birthplace

ZUNI, VIRGINIA  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

William O. Brooks

13. Birthplace

SUFFOLK, VIRGINIA

14. Maiden name

Ruth Davis

15. Birthplace

IVY, VIRGINIA

16. Informant

FLOYD P. MORRIS

Address

KENSINGTON, MD

17. Burial Date thereof

BURIAL

MARCH 25, 1948  
(month) (day) (year)

Cemetery or crematory

SUNSET

Location

CHESTER, VIRGINIA

18. Funeral director

Walter E. Humphrey

Address

Silver Spring, Md

19. Mar 23 1948 Joseph Schaeffe Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 3/22/48 19... at 9:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/5/48

19... to 3/22/48 19...

and that I last saw him alive on 3/22/48 19...

Immediate cause of death

Acute Cardiac Dilatation

DURATION

1 hour

Due to Hypertension

20 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Allen, MD. M. D. or other

Address Kensington, Md Date signed 3/22/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 29 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County... Montgomery  
City or town... Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 day  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 1 day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... D.C. County...  
City or town... Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1421 Saratoga Avenue, N.E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war... ☒

### 3. (a) FULL NAME

MURPHY, Michael Donovan

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single  
6. (b) Name of husband or wife  
7. Birth date of deceased (mo., day, yr.) March 7, 1948 6. (c) If alive, give age... years  
8. AGE: Years Months Days If less than one day  
1 hrs. 10 min.

9. Birthplace Bethesda, Md. (rural)  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name MURPHY, Gerald E.  
13. Birthplace Kansas

MOTHER 14. Maiden name HENBY, Gloria Kay  
15. Birthplace Ill.

18. Informant husband: Gerald E. Murphy, CETM USN

Address USS PHILIPINE SEA, c/o FPO, NY, NY

17. (Burial, cremation, or removal. Which?) burial Date thereof... 3-11-48  
(month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. CHAMBERS

Address 1400 Chapin St. N.W., Wash. D.C.

19. 3-8 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 7 March 19 48 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 March 19 48 to 7 March 19 48

and that I last saw him alive on 7 March 19 48

Immediate cause of death hemiplegia

Other conditions

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. T. FOWLER, Jr. Cdr. MC USN

Address USNH Bethesda, Md. Date signed 3-8-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1700 02959

Reg. Dist. No. 714

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

13th St., between Eastern & Georgia Aves.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State xxxxxxx County xxxxxxxCity or town Washington, D. C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 7422 Georgia Ave., N. W., Apt. 2  
(If rural, give LOCATION)2. (a) If veteran, name war xxxxxxx

## 3. (a) FULL NAME

JOEL ISAAC NORWITZ

## 3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single6. (b) Name of husband or wife xxxxx

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

July 1, 1938

8. AGE:

Years

Months

Days

If less than one day

974

.....hrs.

.....min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Student

11. Industry or business

FATHER

12. Name David Leonard Norwitz13. Birthplace Baltimore, Md.

MOTHER

14. Maiden name Sarah Rebecca Fine15. Birthplace Pocomoke City, Md.16. Informant David Leonard NorwitzAddress 7422 Ga. Ave., N. W., Washington, D.C.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof March 4, 1948  
(month) (day) (year)

Cemetery or crematory

Location Baltimore, Maryland18. Funeral director Sol Levinson & Bros., Funeral D.Address 1124 W. North Ave., Baltimore, Md.19. March 4 1948  
(Date rec'd by registrar)Joseph H. Scherpf  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 4:06 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep Med Exam 1948 to 1948  
and that I last saw him alive on 1948

Immediate cause of death

Cerebral skull

DURATION

Relief

Due to

(accidental)instantly

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

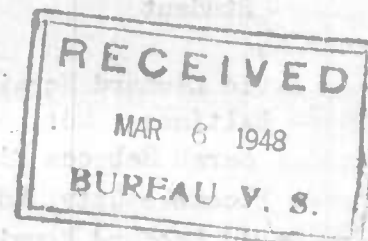
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 3-4-48Where did injury occur? Silver Spring Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) streetMeans of injury Struck by bus Injured at work? no

23. SIGNATURE

Frank J. Broschart M.D.  
Dep Med Exam M. D. or otherAddress Washington Md Date signed 3-4-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02960

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Rural: Bethesda, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Ill. County...  
 City or town... Chicago  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 521 Hazel Avenue, Highland Park  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI

## 3. (a) FULL NAME

Frederic Henderson OTTOWAY, Lt. USN Retired, Inactive Ottawa

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male W-US single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1890

8. AGE: Years 57 Months 11 Days 24 If less than one day  
 .....hrs. ....min.

9. Birthplace... N.Y.  
 (Town, county, and state)

10. Usual occupation... Retired Navy

11. Industry or business

FATHER 12. Name... OTTOWAY, George Henry  
 13. Birthplace... N.Y.

MOTHER 14. Maiden name... SAWYER, Helen  
 15. Birthplace... N.Y.

18. Informant... mother: Mrs. G. H. OttowayAddress 521 Hazel Avenue, Highland Park, Chicago, Ill.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Mar 24, 1948  
 (month) (day) (year)

Cemetery or crematory... Elmwood CemeteryLocation... Lyons, N.Y.18. Funeral director... J.F. BIRCH SONSAddress 3034 M. St. NW, Wash., D.C.

19. 3-21 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 19 March 19 48 at 8:13 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
17 March 19 48 to 19 March 19 48  
 and that I last saw him alive on 19 March 19 48

Immediate cause of death

Cerebral hemorrhage

DURATION

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

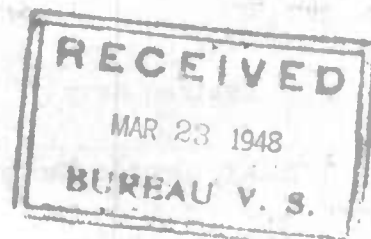
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Boswell, Lt. MC USN M. D. or other

USNH Bethesda, Md. Date signed 3-21-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

02961

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 Years

Hospital, institution, or street address where death occurred:

Home - 4526 Avendale St., Bethesda, Md.How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4526 Avendale Street

(If rural, give LOCATION)

No

2.(a) If veteran, name war

## 3. (a) FULL NAME

ORPHEUS N. PARENT

## 3. (b) Social Security Number

159-10-0294

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Grace G. Parent6. (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) September 10, 1880

## 8. AGE:

Years 67 Months 6 Days 16 It less than one day hrs. min.9. Birthplace Ste.-P., Quebec, Canada  
(Town, county, and state)10. Usual occupation Manager - Carbonie Products11. Industry or business None12. Name Samuel Parent13. Birthplace Canada14. Maiden name Theresa McLeod15. Birthplace Nova Scotia, Canada16. Informant Katherine A. ParentAddress 4526 Avendale St., Bethesda, Md.17. Burial March 29, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.18. Funeral director Wm. Russell RumpreyAddress Bethesda 14, Maryland19. March 29, 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 26 1948 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med Exam case 1948  
and that I last saw him alive on 19

Immediate cause of death

Coronary occlusion

DURATION

did suddenly

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

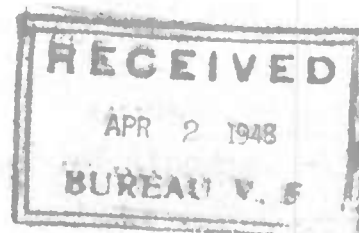
Means of injury Injured at work?

23. SIGNATURE

Frank J. Brorhart M.D.

M. D. or other

Address Washington Md. Date signed 3-26-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02962

Reg. Dist. No. 211

### 1. PLACE OF DEATH:

County Montgomery  
City or town Rural-Comus  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Lifetime  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Rural-Comus  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. None  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

GEORGE A. PEARRE, JR.

### 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Jean D. Pearre

7. Birth date of deceased (mo., day, yr.) February 5, 1874 6. (c) If alive, give age 74 years

8. AGE: Years 74 Months 1 Days 12 If less than one day hrs. min.

9. Birthplace Montgomery County, Maryland  
(Town, county, and state)

10. Usual occupation Retired Lawyer

11. Industry or business

12. Name James Pearre

13. Birthplace Frederick, Maryland

14. Maiden name Ann R. DeLashmutt

15. Birthplace Frederick County, Maryland

16. Informant Miss Nellie Pearre

Address Frederick, Maryland

17. Burial Date thereof March 20, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Olivet Cemetery

Location Frederick, Maryland

18. Funeral director C. E. Cline & Son

Address Frederick, Maryland

19. 19-March 1948 della K. Burdette  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 17th 19 48 at 10:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 48 to March 17 19 48  
and that I last saw him alive on March 17 19 48

Immediate cause of death Chronic Myocarditis  
acute dilatation heart

DURATION  
24 years  
31 days

Due to

Due to

Other conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. H. Smith M.D.  
M.D. or other

Address Frederick Md. Date signed 3-18-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 27 1948

BUREAU V. S.

*As. Gen. M. Smith*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02963

115b  
246

## 1. PLACE OF DEATH:

County Suburban HospitalCity or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 mo. 2 days

Hospital, institution, or street address where death occurred:

Suburban Hospital Georgetown Rd.How long in hospital or institution? 1-18-48 2 mo. 2 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. CountyCity or town Damascus  
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Pickett, Nancy Marie

4. Sex

Female

5. Color of race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan., 16, 1945

8.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

324

hrs.

min.

9. Birthplace Damascus, Maryland  
(Town, county, and state)10. Usual occupation child

11. Industry or business

12. Name Bill Pickett

13. Birthplace

14. Maiden name Hellie Beall15. Birthplace Montgomery Co., Md.16. Informant Bill PickettAddress Damascus17. Burial Date thereof Mar 21-1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Damascus CemLocation Damascus Md18. Funeral director J B Beall IncAddress Damascus Md19. 3/20/48 Wm E Jones  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-20 19 48 at 2 15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on March 20, 1948

Immediate cause of death

acute ulcerative  
entero-colitis.

DURATION

Due to

Due to

Other conditions

Sanguinous toxicillitis  
bronchopneumonia  
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Same as above Date of op

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

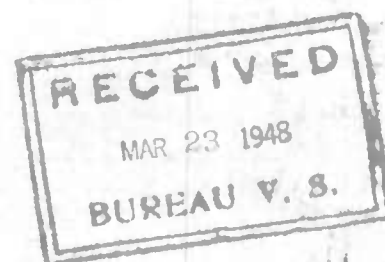
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Keneel, M.D. M. D. or other

Address Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

02964

181

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Gaithersville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 hrs.  
 Hospital, institution, or street address where death occurred:  
Suburban Hospital  
 How long in hospital or institution? 11 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Montgomery  
 City or town Gaithersville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lorraine Prather  
 4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced Single

## 3. (b) Social Security Number

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) Apr. 28 1929  
 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 18 Months 11 Days 26 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Laytonsville, Mont, Md.  
 (Town, county, and state)

10. Usual occupation Student

## 11. Industry or business

12. Name Irving Prather13. Birthplace Laytonsville, Md.14. Maiden name Mamie Jackson15. Birthplace Laytonsville, Md.16. Informant Irving PratherAddress Gaithersville, Md.17. Burial Date thereof April 15 48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Brooke GroveLocation Laytonville Md.18. Funeral director Ray W BarberAddress Laytonville Maryland19. 3/14 48 Wm E Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12 1948 at 8:25 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med exam case 1948 to 19and that I last saw him alive on 1948

Immediate cause of death \_\_\_\_\_

1st, 2nd and 3rd degree burns involvingabout 90% of body(accidental)

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Major findings of operations \_\_\_\_\_

\_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3-12-48Where did injury occur? Gaithersville Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of Injury Poured coal oil on stove and fired at home23. SIGNATURE Frank J. Broschart M.D. M. D. or otherAddress Gaithersville Md. Date signed 3-13-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 17 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02965

216

Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Wash., D.C. County...  
 City or town... (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 23 2nd St., N.E., Apt. #21  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war... WWI

## 3. (a) FULL NAME

PREIS, Edward Burke

## 3. (b) Social Security Number

4. Sex Male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mary Preis  
 6. (c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) July 3, 1874  
 8. AGE: Years 73 Months 8 Days 11 If less than one day ..... hrs. .... min.

9. Birthplace... La. (Town, county, and state)  
 10. Usual occupation Doctor  
 11. Industry or business  
 12. Name PREIS, William H. dec.  
 13. Birthplace Ala.  
 14. Maiden name BURKE, Helen dec.  
 15. Birthplace Ky.

16. Informant wife: Mrs. Mary Preis  
 Address 23 2nd St., N.E., Apt. #21, Wash., D.C.  
 17. burial Date thereof 3-17-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Arlington National  
 Location Arlington, Va.  
 18. Funeral director W. W. CHAMBERS Chm.  
 Address 517 11th St., N.E., Wash., D.C.  
 19. 3-14 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 14 March 19 48 at 6:25 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
5 March 19 48 to 14 March 19 48  
 and that I last saw him alive on 14 March 19 48

Immediate cause of death Congestive  
Failure & Broncho pneumonia

## DURATION

Due to Generalized Atherosclerosis  
Coronary Sclerosis

Other conditions Fracture rib  
Ventral Hernia  
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op. ....  
 Autopsy results Confirmed & done  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide accident Date of about March 14, 1948  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury fell against sheet curbing when he  
stepped out of his car  
on curbing  
 C. M. DURNING, Lt. JG MC USNR  
 23. SIGNATURE... USNH Bethesda, Md. M. D. or other  
 Address... Date signed 3-14-48

**RECEIVED**

**MAR 18 1948**

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02966

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

### 1. PLACE OF DEATH:

County Montgomery  
City or town Parkersburg Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Entire life  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Parkersburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Rural Rt 28  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

JAMES Tilman PURDUM

### 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Carrie H. Purdum

7. Birth date of

deceased (mo., day, yr.)

Oct 25 1862

6. (c) If alive, give age 82 years

8. AGE:

Years

Months

Days

It less than one day

86

6

5

hrs.

min.

9. Birthplace

Samtont Md.

(Town, county, and state)

10. Usual occupation

Retired Laborer

11. Industry or business

FATHER

12. Name

James W. Purdum

13. Birthplace

Md.

MOTHER

14. Maiden name

Father Fletcher

15. Birthplace

Md.

16. Informant

Carrie H. Purdum

Address

Samtont Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

4/11/48

Cemetery or crematory

Samtont Cemetery

Location

Samtont Md.

18. Funeral director

P. B. Gattner

Address

Father Fletcher Md.

19.

(Date rec'd by registrar)

March 30 1948 Alinda I. Corke

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 30 March 19 48 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1948 to 29 March 1948  
and that I last saw him alive on 29 March 1948

Immediate cause of death

Coronary atherosclerosis

Due to

arteriosclerosis

Due to

age

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John S. Sawatch

M. D. or other

Address

P.O. Boyd, Md.

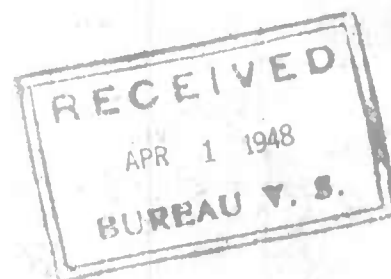
Date signed 29 March

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 12 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 month, 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ga. County \_\_\_\_\_  
 City or town Savannah  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 215 W. Anderson  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWII

## 3. (a) FULL NAME

QUARLES, Thomas Andrew, Jr.

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single  
 8. (b) Name of husband or wife \_\_\_\_\_ 8. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 26, 1920  
 8. AGE: Years 27 Months 9 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Ga.  
 (Town, county, and state)  
 10. Usual occupation Navy  
 11. Industry or business \_\_\_\_\_  
 12. Name QUARLES, Thomas A., Sr.  
 13. Birthplace Ga.  
 14. Maiden name HUGHES, Anna,  
 15. Birthplace Ga.

16. Informant mother: Mrs. Anna H. Quarles  
 Address 215 W. Anderson, Savannah, Ga.  
 17. burial Date thereof 3-28-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Bonaventure Cemetery  
 Location Savannah, Ga.  
 18. Funeral director W. W. CHAMBERS  
 Address 1400 Chapin St., N.W., Wash., D.C.  
 19. 3-25 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 25 March 19 48 at 8:15 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 February 19 48 to 25 March 19 48  
 and that I last saw him 1m alive on 25 March 19 48  
 Immediate cause of death Malignant Metastatic Pulmonary DURATION 3 mons  
Teratoma, Testis 3 mons  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ injured at work? \_\_\_\_\_  
 23. SIGNATURE H. R. COOPER, Lt. MC USN M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 3-25-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

942

02968

Reg. Diat. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 hours  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1217 Vermont Avenue, N.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI ✓

## 3. (a) FULL NAME

QUICK, Willard Voyce

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) July 16, 1896  
 8. AGE: Years 51 Months 7 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
 (Town, county, and state)  
 10. Usual occupation Clerk  
 11. Industry or business Veterans Administration  
 FATHER 12. Name QUICK, William V. dec. \_\_\_\_\_  
 13. Birthplace Va.  
 MOTHER 14. Maiden name RUPPERT, Annie E. dec. \_\_\_\_\_  
 15. Birthplace Wash., D.C.

16. Informant sister: Mrs. Ruth D. Dowden  
 Address 635 N. Edison St., Arlington, Va.  
 17. burial Date thereof 3-15-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
Arlington, Va.  
 Location

18. Funeral director S. H. CHINERS 826  
 Address 2901 14th Street, N.W., Wash., D.C.  
Mary C. Patterson

19. 3-15 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 19 48 at 9:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
14 March 19 48 to 14 March 19 48  
 and that I last saw him alive on 14 March 19 48

Immediate cause of death Coronary  
Occlusion DURATION few min.

Due to Arteriosclerosis  
Hypertension

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. M. DURNING Lt. JG MC USNR  
C. M. DURNING  
 M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 3-15-48

RECEIVED

MAR 18 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Brighton Hotel, 2123 Calif. St., N.W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war Sp. Am., WWI & II

## 3. (a) FULL NAME

REEVES, Joseph Mason, Admiral USN Ret. Inact.

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) November 20, 1872 8. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 75 Months 4 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ill. (Town, county, and state)  
 10. Usual occupation Navy (retired)  
 11. Industry or business \_\_\_\_\_  
 12. Name REEVES, Joseph C. dec  
 13. Birthplace Mass.  
 14. Maiden name BREWER, Frances dec.  
 15. Birthplace Mass.

16. Informant son: Mr. J. M. Reeves,  
 Address 406 N. Normandy Pl., Los Angeles, Calif.  
 17. burial Date thereof 3-30-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Naval Cemetery, Naval Academy  
Annapolis, Maryland  
 Location \_\_\_\_\_

18. Funeral director S. H. HINES  
 Address 2901 14th St., N.W., Wash., D.C.  
 19. 3-26 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 19 48 at 7:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
22 March 19 48 to 25 March 19 48  
 and that I last saw him 1m alive on 25 March 19 48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_  
Coronary Heart Disease,  
Arterio sclerotic  
 Due to Arteriosclerosis, general  
 Due to \_\_\_\_\_  
 Other conditions Pericarditis, Chronic  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE F. R. LANG, Capt. MC USN  
 M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 3-26-48

**RECEIVED**

**MAR 31 1948**

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

02970

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 yrs  
 Hospital, institution, or street address where death occurred:  
4710 Morgan Dr.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4710 Morgan Dr  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Eloise Richardson  
 6. (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) June 6 1880

8. AGE: Years 67 Months 9 Days 16 If less than one day hrs. min.

9. Birthplace New York City  
 (Town, county, and state)

10. Usual occupation Businessman

11. Industry or business (retired)

12. Name Henry W. Richardson

13. Birthplace Ireland

14. Maiden name unknown

15. Birthplace New York

16. Informant Mrs Eloise Richardson

Address 4710 Morgan Dr. Bethesda Md

17. Cremation Date thereof 3/24/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory F & Lincoln

Location Nash

18. Funeral director The S. H. Hines Co.

Address 2901-14th St N.W.

19. Mar 23 1948 Mr E Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1948 at 3:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death

## DURATION

Coronary occlusion death

Due to

Due to

Due to

Other condition

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brounhart M.D. M. D. or other

Address Washington Md Date signed 3-23-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 15 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 month, 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County \_\_\_\_\_  
 City or town Morgantown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 520 Rebecca Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWI

## 3. (a) FULL NAME

SCHERR, William Burkhart

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Beulah Scherr  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) September 27, 1893  
 8. AGE: Years 54 Months 5 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace W. Va.  
 (Town, county, and state)  
 10. Usual occupation Retired Navy  
 11. Industry or business \_\_\_\_\_  
 FATHER 12. Name SCHERR, Julius  
 13. Birthplace Switzerland  
 MOTHER 14. Maiden name SIEVERS, Emelia ded.  
 15. Birthplace Md.

16. Informant wife: Mrs. Beulah Scherr  
 Address 520 Rebecca St., Morgantown, W. Va.  
 17. burial Date thereof 3-23-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Virginia  
 18. Funeral director S. H. HINES Rev. S. A. Hines W. H.  
 Address 2901 14th St., N.W., Wash., D.C.  
Mary C. Patterson  
 19. 3-22 19 48 Mary C. Patterson Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 21 March 19 48 at 2:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
6 February 19 48 to 21 March 19 48  
 and that I last saw him alive on 21 March 19 48

Immediate cause of death  
Adenocarcinoma of the rectum  
with local and distant metastasis

## DURATION

3 yrs

Due to Bronchopneumonia, bilateral

Due to \_\_\_\_\_

Other conditions 123-2

(Include pregnancy within 3 months of death)

Major findings of operations Colostomy 2-9-48  
Lobotomy, Prefrontal Date of op. 3-12-48

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury W. J. James Injured at work? \_\_\_\_\_

23. SIGNATURE W. J. JAMES, S., Lt. Cdr. MC USN  
 M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 3-22-48

RECEIVED

MAR 23 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02972

216

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County.....Montgomery  
City or town.....Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....4 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution?.....4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....D.C. County.....  
City or town.....Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4314 12th Place, N.E.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....WWI

### 3. (a) FULL NAME

SCHNABEL, William

### 3. (b) Social Security Number

4. Sex.....male 5. Color or race.....W-US 6.(a) Single, married, widowed, or divorced.....married  
6.(b) Name of husband or wife.....Francis E. Schnabel  
6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.).....September 20, 1883  
8. AGE: Years.....64 Months.....5 Days.....17 If less than one day..... hrs. .... min.

9. Birthplace.....Ark.  
(Town, county, and state)  
10. Usual occupation.....unknown  
11. Industry or business.....  
12. Name.....SCHNABEL, Valentine dec.  
13. Birthplace.....Germany  
14. Maiden name.....unknown dec.  
15. Birthplace.....Germany

16. Informant.....wife: Mrs. Francis E. Schnabel  
Address.....4314 12th Place, N. E., Wash., D.C.  
17.....burial Date thereof.....3-10-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory.....Arlington National  
Location.....Arlington, Va.

18. Funeral director.....W. W. DEAL  
Address.....4812 Georgia Avenue, N. W., Wash., D.C.

19.....3-8 19 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....7 March 19 48 at 12:05P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
3 March 19 48 to 7 March 19 48  
and that I last saw him alive on 7 March 19 48

Immediate cause of death.....marked  
bilateral

Due to.....Bronchopneumonia wk. 2  
Coronary Artery dis. 2 yrs +  
arteriosclerosis with indif  
Other conditions.....decompensation  
old pleural adhesions  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....as above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury.....F. E. Wetzel Injured at work?

23. SIGNATURE.....F. E. WETZEL, Lt. MC USN

Address.....USNH Bethesda, Md. Date signed.....3-8-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02973

93d

216

### 1. PLACE OF DEATH

County Montgomery

City or town CHEY CHASE  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

11 E. MELOSE ST.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County Montgomery

City or town CHEY CHASE, MD.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 EAST MELOSE ST.  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

MR. ROBERT A SHEALEY Preston

### 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Eleanor Delano Shealey

7. Birth date of deceased (mo., day, yr.) December 5, 1873 8. (c) If alive, give age 74 years

8. AGE: Years 74 Months 3 Days 19 If less than one day hrs. min.

9. Birthplace Towson, Maryland  
(Town, county, and state)

10. Usual occupation Attorney

11. Industry or business --

12. Name David Shealey

13. Birthplace Towson, Maryland

14. Maiden name Elizabeth ?

15. Birthplace Towson, Maryland

16. Informant Elliott J. Dent, Jr.

Address 3517 Springland Lane, N.W., Wash.

17. Burial March 26, 1948  
(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Washington, D. C.

18. Funeral director Gas Sawlins Sons

Address 7756 R. AVE. N.W. WASH. DC

19. 3/24 19. 48 Thos E Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19. 48 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 19. 48 to Mar 24 19. 48 and that I last saw him alive on March 23 19. 48

Immediate cause of death Hypertensive Heart Disease with Congestive Failure DURATION 2 mo.  
Due to Essential Hypertension

Other conditions Hypostatic Pneumonia  
(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. None

Autopsy results None  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE E Herbert Bauer, M.D. M. D. or other

Address 1912-R. St. NW Date signed 3/24/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02974

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MONTGOMERYCity or town LANSING PARK

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 MONTHS

Hospital, institution, or street address where death occurred:

805 MAPLE AVENUEMRS. JOAN FEE'S NURSING HOME

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State VIRGINIA CountyCity or town Hume

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

LYLE M SMITH

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife DORA B SMITH7. Birth date of deceased (mo., day, yr.) Oct. 7, 1899

6. (c) If alive, give age years

8. AGE: Years 70 Months Days If less than one day hrs. min.9. Birthplace PATAHANNOCK

(Town, county, and state)

10. Usual occupation Sawmill Owner

11. Industry or business

12. Name John A. Smith13. Birthplace Va.14. Maiden name Polly Jewel15. Birthplace Va.16. Informant Charles C. Celery, Jr.Address 805 Maple Ave. Takoma Park17. Removal to D.C. (Burial, cremation, or removal, Which?) March 30, 1948

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director W. W. Chambers Co.Address 517 - 11th St SE19. March 30, 1948

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948, at 12:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-4 1948, to 3-30 1948and that I last saw him alive on 2-4 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to Arteriosclerotic Hypertension  
Cardiovascular Disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

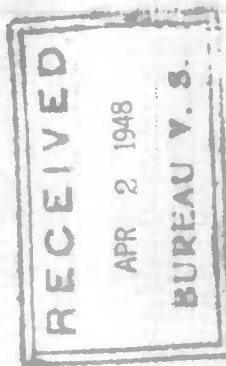
23. SIGNATURE Dean H. Shady M.D.Address 112 Carroll St NW Date signed 3-30-48

washington DC

Montgomery County Coroner notified  
and he will appear

Lean H Harding MD  
113 Carroll St NW  
Wash DC

March 30, 1948



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02975

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 17 hours  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 17 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Pr. Gen.  
City or town Seat Pleasant  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6309 Foot St.,  
(If rural, give LOCATION)  
2. (a) If veteran, name war WWI

### 3. (a) FULL NAME

SPEAKES, Levi Joseph

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Mabel Speakes  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) March 10, 1890  
8. AGE: Years 58 Months 0 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
(Town, county, and state)  
10. Usual occupation Retired Navy Yard Employee  
Government  
11. Industry or business  
FATHER 12. Name SPEAKES, Joseph dec.  
13. Birthplace Va.  
MOTHER 14. Maiden name \_\_\_\_\_ dec.  
15. Birthplace Va.

16. Informant wife: Mrs. Mabel Speakes  
Address 6309 Foot St., Seat Pleasant, Md.  
17. burial Date thereof 3-31-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Arlington National  
Location Arlington, Virginia

18. Funeral director W. W. CHAMBERS JR.  
Address 517 11th St., S.E., Wash., D.C.  
Mary C. Patterson  
19. 3-29-48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1948 at 8:15 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 March 1948 to 29 March 1948  
and that I last saw him alive on 29 March 1948  
Immediate cause of death Cerebral Hemorrhage  
DURATION 36 hrs  
Due to Hypertension, arterial  
Due to \_\_\_\_\_  
Other conditions Hypertensive Heart Disease  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results as above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury J.C. Wetzel Injured at work? \_\_\_\_\_  
F. E. WETZEL, Lt. MC USN  
23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_  
Address USNH Bethesda, Md. Date signed 3-29-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NG

RECEIVED  
MAR 31 1948  
BUREAU V. S.

VS A15 9-45-15M



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02976

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

### 1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 hours 5 min

Hospital, institution, or street address where death occurred:  
Washington Sanitarium and Hospital

How long in hospital or institution? 8 hrs. 5 min

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5633 Green Chapel Manor  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Mr Clarence Seymour Steeves

### 3. (b) Social Security Number

4. Sex male 5. Color or race cauc. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mrs Ana Steeves

7. Birth date of deceased (mo., day, yr.) January 29 1864 6.(c) If alive, give age years

8. AGE: Years 84 Months 1 Days 22 If less than one day 18 hrs. 35 min.

9. Birthplace N. S. Canada  
(Town, county, and state)

10. Usual occupation Retired Carpenter

11. Industry or business

12. Name Mr. Fred Steeves

13. Birthplace N. S. Canada

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Hospital records and relatives of deceased

Address Wash. San. & Hospi. Takoma Park, Md.

17. Burial Date thereof March 26, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Geo. Washington Memorial Park

Location Ridge Pt. Hyattsville, Md.

18. Funeral director J. Arthur Walters

Address 254 Carroll St. N.W. Takoma Park, Md.

19. March 24 1948 Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1948 at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to March 23 1948

and that I last saw him alive on March 23 1948

Immediate cause of death Lobar Pneumonia DURATION Terminal

Due to

Due to

Other conditions Arteriosclerosis ? years

Cardiac dilatation Terminal

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert H. Hare M. D.

Address Takoma Park, Md. Date signed 3/23/48

PLEASE WRITE PLAINLY IN INK. Supply every item of information carefully. Physicians: Please write the causes of death clearly a

ne correct age

RECEIVED

MAR 30 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

### 1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanatorium & Hospital

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 Cedar Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Sterling, Mrs. Mary

### 3. (b) Social Security Number

4. Sex Female 5. Color or race Hebrew 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Sterling, Mr. Isaac

Deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859 ?

8. AGE: Years 89 Months ? Days ? If less than one day hrs. min.

9. Birthplace Chernigov, Russia  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name William Zetlin

13. Birthplace Russia

14. Maiden name Roth

15. Birthplace Russia

16. Informant Hospital Records

Address

17. Burial Date thereof 3-23-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen

Location Washington, D.C.

18. Funeral director B. Samarsky & son

Address 3501 - 14 St. N.W.

19. March 23 19 48 J. H. D. D.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 19 48 at 1:08 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5 19 48 to March 23 19 48

and that I last saw her alive on March 22 (9:00 AM) 19 48

Immediate cause of death Metastatic Carcinoma to lungs

Due to Adeno Carcinoma of right breast

Due to Metastatic Ca. to the femur & brain

Other conditions Generalized abdominal carcinomatosis & sepsis -  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none performed in this case

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lionel Roth M.D.

Address Washington, D.C. Date signed 3/23/48

Takoma Park, Md.

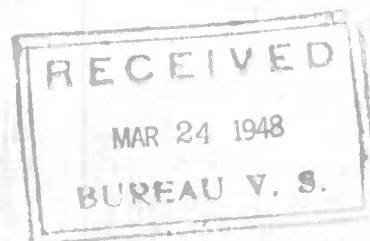
MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4921



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02978

216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 Years  
 Hospital, institution, or street address where death occurred:  
4509 Highland Avenue, Bethesda, Md.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4509 Highland Avenue  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

SUSIE L. STRICKLER

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Samuel B. Strickler

7. Birth date of deceased (mo., day, yr.) January 27, 1885 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 63 Months 63 Days 11 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Amissville, Rappahannock, Va.  
 (Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own Home

12. Name John Mason Lawrence  
 13. Birthplace Virginia

14. Maiden name Sarah Priest  
 15. Birthplace Virginia

16. Informant Benton W. Strickler  
 Address 4509 Highland Ave., Bethesda, Md.

17. Burial Date thereof March 11, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Amissville Cemetery  
 Location Amissville, Virginia

18. Funeral director Wm Reuben Humphrey  
 Address 7557 Wisconsin Ave. Bethesda, Md

19. 3/ 19 48 Am E Johnson Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 19 48 at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 1940, to March 8 19 48  
 and that I last saw her alive on March 5 19 48

Immediate cause of death  
1/ Malnutrition  
2/ Pulmonary Bronch. pneumonia  
3/ Carcinoma of stomach with metastasis to liver, gall bladder, diaphragm and lymph glands

## DURATION

2 months  
4 days  
3 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Benjamin M.D.  
 Address Bethesda, Md Date signed 3/8/48

RECEIVED

MAR 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

131a

02979

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Wt. Zion Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County MontgomeryCity or town Rural Mt. Zion Md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war 2d Army I

## 3. (a) FULL NAME

Alfred H. Swails

## 3. (b) Social Security Number

215-2637064. Sex Male 5. Color or race Cal 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Aug 13 18958. AGE: Years 52 Months 7 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farmer12. Name Alfred H. Swails13. Birthplace Md14. Maiden name Sarah Lamhorn15. Birthplace Md16. Informant Sarah SwailsAddress Wt Zion Md17. Burial Date thereof 3-22-1948  
(Burial, cremation, or removal, which) (month) (day) (year)Cemetery or crematory Wt Zion MdLocation Montgomery Co Md18. Funeral director W. H. BarberAddress off on the Md19. 3-22 1948 Gertrude B. Lawler  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/20/48 1948 at 1st21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/26 1948 to 3/20 1948and that I last saw him alive on \_\_\_\_\_ 1948Immediate cause of death AnasarcaDue to Suppurative Cardiovascular DURATION 1 moDue to renal disease yrs 48

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles H. Sigler MD M. D. or other B. B. Sigler MDAddress Bandy Spring Md Date signed 3/22/48

RECEIVED

MAR 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda, (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 23 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 505 9th Street, S. E.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war Sp. Am.

## 3. (a) FULL NAME

SWEENEY, Richard Hammond

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) August 5, 1879

8. AGE: Years 68 Months 6 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
(Town, county, and state)10. Usual occupation Printer

11. Industry or business \_\_\_\_\_

FATHER 12. Name SWEENEY, Richard H. dec. \_\_\_\_\_  
 13. Birthplace Md.

MOTHER 14. Maiden name KLINHANSE, Catherine dec. \_\_\_\_\_  
 15. Birthplace Wash., D.C.

16. Informant brother: Mr. N. C. Sweeney, Sr.Address 913 Quincy St., N.E., Wash., D.C.

17. burial Date thereof 3-26-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director W. W. CHAMBERS P.H.Address 517 11th St., S.E., Wash., D.C.

19. 3-24 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 23 March 19 48 at 1:55 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
1 March 19 48 to 23 March 19 48  
 and that I last saw him alive on 23 March 19 48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Massive hemorrhage into  
gastrointestinal tract

Due to Carcinoma of Pancreas

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

J. A. MURPHY, Jr.  
J. A. MURPHY, Jr. MC USN

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 3-24-48

RECEIVED

MAR. 26 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Va. County \_\_\_\_\_  
 City or town Triangle  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 35  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Robert Eric TOSDALE

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 8.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) February 21, 1948  
 8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 28 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
 12. Name TOSDALE, Orlando S.  
 13. Birthplace Mass.  
 14. Maiden name JEFFERY, Jean  
 15. Birthplace Wis.

16. Informant father: Capt. Orlando S. Tosdale USMC  
 Address Quantico Air Station, Quantico, Va.  
 17. burial Date thereof 3-22-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.

18. Funeral director W.W. CHAMBERS  
 Address 3072 M St. NW, Wash., D.C.  
 19. 3-21 19 48 Mary E. Patterson Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 19 March 19 48 at 10:15P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
5 March 19 48 to 19 March 19 48  
 and that I last saw him alive on 19 March 19 48

Immediate cause of death atelectasis & broncho-  
pneumonia

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
Atelectasis, bilateral, marked; bronchopneumo-  
nia; Epidural hemorrhages  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. K. WISE, Lt. JG USNR  
 Address USNH Bethesda, Md. Date signed 3-21-48  
 M. D. or other

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 25 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223-

### 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium

How long in hospital or institution? 1 month

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 9002 Bradford Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Herbert Allen Vandeman

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Nina M. Vandeman

7. Birth date of deceased (mo., day, yr.) June 19 1878

6.(c) If alive, give age years

8. AGE: Years 69 Months 8 Days 16 If less than one day  
hrs. min.

9. Birthplace Ashland, Nebraska  
(Town, county, and state)

10. Usual occupation Retired Minister

11. Industry or business

12. Name Augusta W. Vandeman  
13. Birthplace Ohio

MOTHER  
14. Maiden name Sarah Thrasher  
15. Birthplace Indiana

16. Informant Sanitarium Records

Address Takoma Park, Md.

17. Burial Date thereof Mar. 8, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Green Nash Mem. Cemetery

Location Edge Road, Bethesda, Md.

18. Funeral director J. ARTHUR WALTERS

Address 254 Carroll St. N.W., Takoma Park, D.C.

19. March 7 19 48 J. Arthur Walters  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 48 at 10:04 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2 19 48 to March 6 19 48  
and that I last saw him alive on March 6 19 48

Immediate cause of death Multiple Pulmonary Emboli

DURATION Terminal

Due to Carcinoma of Rectum

6 mos?

Due to Carcinoma of Liver

5 mos.

Other conditions Coronary Thrombosis

3 wks ±

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Confirm above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert A. Hare MD M. D. or other

Address Takoma Park, Md Date signed 3/6/48

MARGIN RESERVED FOR BINDING

VS AT5 9-45-15M

VS AT5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contact age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

MAR 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02983

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 4 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 month, 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 638 East Capital St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWI

## 3. (a) FULL NAME

WEBBER, Charles Oran VAP

## 3. (b) Social Security Number

4. Sex Male 5. Color or race W-U.S. 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Gwyneth G. Webber  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) August 23, 1889  
 8. AGE: Years 58 Months 6 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Iowa  
 (Town, county, and state)  
 10. Usual occupation Government Printing Office  
 11. Industry or business \_\_\_\_\_  
 FATHER 12. Name WEBBERS, Charles E. dec. Ill.  
 13. Birthplace CALIF.  
 MOTHER 14. Maiden name Genevra A.  
 15. Birthplace Iowa

18. Informant wife: Mrs. Gwyneth G. Webber  
 Address 638 East Capital St.,  
 17. burial Date thereof 3-9-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director W.W. Chambers Funeral Home  
 Address 1400 Chapin St. NW. Washington, D. C.  
Mary C. Patterson  
 19. 3-6-48 19 48 Mary C. Patterson  
 (Date Rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 March 19 48 at 2:35 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2 19 48 to 6 March 19 48  
 and that I last saw him alive on 6 March 19 48  
 Immediate cause of death Acute leukemia DURATION Weeks  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions 13 mch. pneumonia days  
Intestinal Obstruction days  
 (Include pregnancy within 3 months of death)  
 Major findings of operations Lymphatic hypertrophy  
terminal ileum Date of op. March 1-1948  
 Autopsy results Acute leukemia and Bronchopneumonia  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
12. N. Shelly  
 23. SIGNATURE R. N. SHELLEY, Cdr. MC USN M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 3-6-48

RECEIVED

MAR 9 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02984

838

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 1/2 hours  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 5 1/2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County P. Ges  
 City or town Cheverley  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2308 Crestlawn Place  
 (If rural, give LOCATION)  
 2(a) If veteran, name war WWI

## 3. (a) FULL NAME

WENTWORTH, Reginald Hollis

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Lea L. Wentworth  
 7. Birth date of deceased (mo., day, yr.) January 11, 1881 8. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 67 Months 2 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mass. (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business Washington Railroad Supervisor  
 12. Name unknown dec.  
 13. Birthplace unknown  
 14. Maiden name unknown dec.  
 15. Birthplace unknown

16. Informant wife: Mrs. Lea L. Wentworth  
 Address 2308 Crestlawn Place, Cheverley, Md.

17. burial Data thereof 4-2-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Virginia  
W. W. CHAMBERS

18. Funeral director RMB  
 Address 5801 Cleveland Avenue, Riggsdale, Md.  
Mary C. Patterson

19. 3-31 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 31 March 19 48 at 8:12 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
DEP. MED. EXAMINER'S CASE 19  
 and that I last saw him alive on 19

Immediate cause of death Massive Cerebral infarction 5 1/2 hrs.  
 DURATION

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions hypertension ?  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results same as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury Frank J. Broschart Injured at work?  
FRANK J. BROSCART, M.D.

23. SIGNATURE DEPUTY MED. EXAMINER M. D. or other  
 Address Gaithersburg, Md. Date signed 3-31-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Garrett Park  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Box 166

How long in hospital or institution?

None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Garrett Park  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Box 166

(If rural, give LOCATION)

2. (a) If veteran, name war

None

## 3. (a) FULL NAME

Hennings B. Whalen

## 3. (b) Social Security Number

213-10-7805

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lottie B. Whalen

6. (c) If alive, give age

37

years

7. Birth date of

deceased (mo., day, yr.)

October 13, 1903

8. AGE:

Years

Months

Days

If less than one day

4444429

hrs.

min.

8. Birthplace

Derwood Maryland

(Town, county, and state)

10. Usual occupation

Bus Driver

11. Industry or business

None

FATHER

12. Name

Martin T. Whalen

13. Birthplace

Maryland

MOTHER

14. Maiden name

Emily T. Lowe

15. Birthplace

Maryland

16. Informant

Lottie B. Whalen-Wife

Address

Garrett Park, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar 14, 1948

(month) (day) (year)

Cemetery or crematory

Forest Oak Cemetery

Location

Gaithersburg, Maryland

18. Funeral director

Address

Bethesda, Maryland

19.

(Date rec'd by registrar)

3/12/48Wm E Jones

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 12, 1948 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1947 to Sept. 1948  
 and that I last saw him alive on Sept. 1948

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

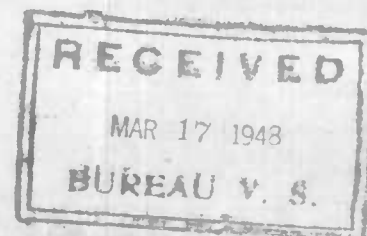
23. SIGNATURE

Frank J. Brochard M.D.

M. D. or other

Address

4000 Wisconsin Ave. N.W.Date signed 3/12/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02986  
Reg. Dist. No. 211

### 1. PLACE OF DEATH:

County Montgomery  
City or town Orney  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 Day  
Hospital, institution, or street address where death occurred:  
The Montgomery County General Hospital Inc.  
How long in hospital or institution? 1 DAY

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State District of Columbia County  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1435 Spring Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3.(a) FULL NAME

Charles E White

### 3.(b) Social Security Number

#### 4. Sex

Male

#### 5. Color or race

White

#### 6.(a) Single, married, widowed, or divorced

Married

#### 6.(b) Name of husband or wife

William Z. White

#### 7. Birth date of deceased (mo., day, yr.)

June 21 1893

#### 6.(c) If alive, give age years

#### 8. AGE:

Years

Months

Days

If less than one day

54

8

8

hrs. min.

#### 9. Birthplace

Norbeck, Montgomery Maryland  
(Town, county, and state)

#### 10. Usual occupation

Superintendent of Maintenance

#### 11. Industry or business

#### FATHER

#### 12. Name

George E. White

#### 13. Birthplace

Maryland

#### MOTHER

#### 14. Maiden name

Mary E. Hawes

#### 15. Birthplace

Hunting Hill, Montgomery Maryland

#### 16. Informant

Mrs. Charles E. White

#### Address

1435 Spring Road Washington D.C.

#### 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 16 1948  
(month) (day) (year)

#### Cemetery or crematory

Arlington Cem

#### Location

Arlington Co. Va.

#### 18. Funeral director

#### Address

The S. H. Nines Co.  
2901 - 14th St. N.W.

#### 19.

3-13

1948

Gertrude B Lowler  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1948 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/1 1947 to 3/13 1948

and that I last saw him alive on 3/13 1948

#### Immediate cause of death

acute cardiac failure

#### DURATION

3 days

#### Due to

Coronary occlusion

#### Due to

Hypertensive Cardiac-vascular disease

#### Other conditions

(Include pregnancy within 3 months of death)

#### Major findings of operations

Date of op.

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

#### 23. SIGNATURE

M. D. or other

Signature Sandysp Date signed 3/13/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITHOUT FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 02987  
 940  
 Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County... MONTGOMERYCity or town... OLNEY  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... MontgomeryCity or town... Laytonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Harry Griffith White

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 8. (b) Name of husband or wife

Margaret R White6. (c) If alive, give age 43 years

## 7. Birth date of deceased (mo., day, yr.)

September 22 1891

## 8. AGE:

Years

56

Months

5

Days

29

If less than one day

hrs.

min.

## 9. Birthplace

Clarksburg Maryland  
(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

FATHER

## 12. Name

Nathan White

## 13. Birthplace

Clarksburg Maryland

MOTHER

## 14. Maiden name

Julia Griffith

## 15. Birthplace

Laytonsville Maryland

## 16. Informant

Margaret R White

## Address

Laytonsville Md

## 17. Burial

Burial

## Date thereof

March 22 1948  
(month) (day) (year)

## Cemetery or crematory

Laytonsville Md

## Location

Molton Co

## 18. Funeral director

Repp Barber

## Address

Laytonsville Md

## 19. 3-28

1948

## Date rec'd by registrar

Gertrude B Lawler

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1948 at 4:05 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 20 1948 to March 20 1948 and that I last saw him alive on March 20 1948

Immediate cause of death

Myocardial Infarction, Undetected, severe  
Due to Coronary Thrombosis Undetected

DURATION

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jack Altmacher M.D.  
Address Laytonsville Md Date signed Mar 20 1948

RECEIVED

MAR-27 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02988

Reg. Dist. No. 14

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
902 Philadelphia Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 902 Philadelphia Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

JOHN WOLF

## 3. (b) Social Security Number

no

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife Ada7. Birth date of deceased (mo., day, yr.) Oct. 4th. 1868

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day  
79 5 8 hrs. min.9. Birthplace Austria  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name John Wolf13. Birthplace Austria14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs. Edna ThurberAddress 902 Phila. Ave. Silver Spring.17. Removal Date thereof 3/13/1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Walnut HillsLocation Cincinnati, Ohio18. Funeral director Wane E. Humphrey, Inc.Address Silver Spring, Md.19. Mar. 13 19 48 Josephine K. Schaeffer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 19 48 at 8 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Feb. 1 19 48, to March 12 19 48and that I last saw him alive on March 2 19 48Immediate cause of death Ventricular Fibrillation DURATION  
1/2 hr.Due to Arteriosclerotic Heart Disease Several  
years

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L.B. Snow M. D. or otherAddress 914 Sligo Avenue Date signed 3-13-48  
Silver Spring, Md.

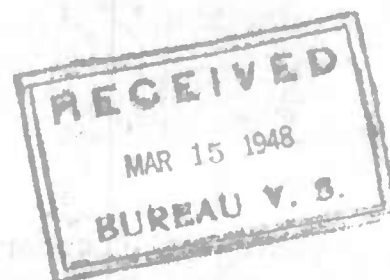
MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

914 S. 1st Ave.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Rural near Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 6047- River Road, Home.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Rural near Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6047- River Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Lillian Wood

### 3. (b) Social Security Number

not known

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband

Frank Wood

7. Birth date of deceased (mo., day, yr.)

May 4 - 1876.

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

71

10

20

hrs.

min.

9. Birthplace

Quince Orchard - Montgomery Co., Md.  
(Town, county, and state)

10. Usual occupation

Char. lady.

11. Industry or business

M. S. Government Service

12. Name

Foster Pickle

13. Birthplace

Montgomery Co. - Md.

14. Maiden name

Annie Scott

15. Birthplace

Montgomery Co. - Md.

16. Informant

Margaret Wood

Address

6047- River Rd. - Bethesda, Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

3/28/48

Cemetery or crematory

Quince Orchard

Location

Frayer Funeral Home

18. Funeral director

389- R.D. Ave NW

Address

3/24 48

19. (Date rec'd by registrar)

Wm E Jones

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1948 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to March 24 1948 and that I last saw him alive on March 24 - 1948.

Immediate cause of death

Cerebral hemorrhage

DURATION

2 years

Due to Arterio-sclerosis and hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wheeler Duff - M.D.

M. D. or other

Address

Bethesda, Md.

Date signed

3-24-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

MAR 29 1948

**BUREAU V. S.**